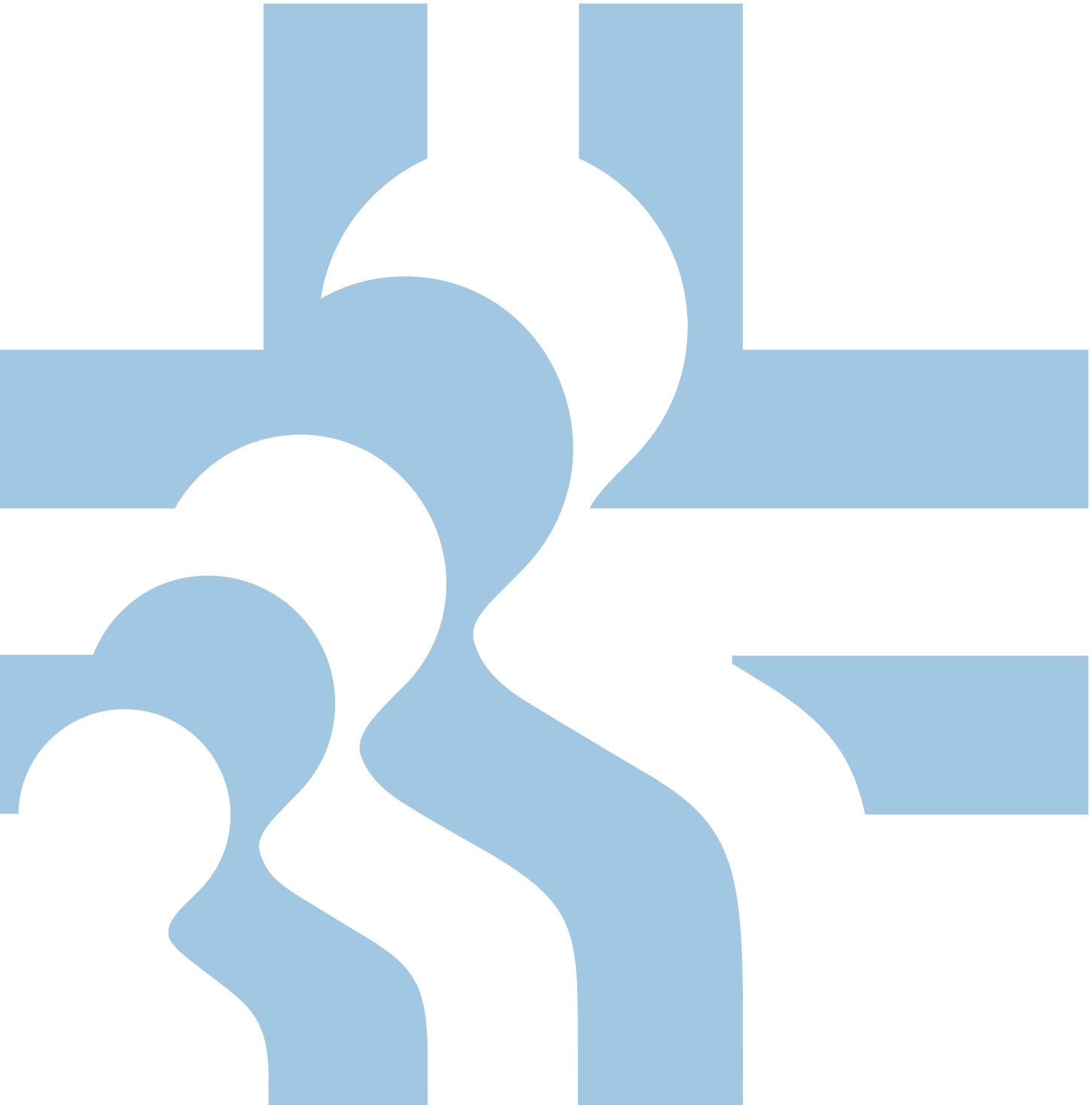
Rhode Island Department of Health

Rhode Island Tobacco Control Program

2006 Strategic Plan for Eliminating Tobacco-Related Health Disparities in Rhode Island

Developed by the Rhode Island Tobacco-Related Disparities Workgroup

RHODE ISLAND DEPARTMENT OF HEALTH



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Addressing Tobacco-Related Health Disparities in Rhode Island

Tobacco is the leading preventable cause of death in the United States. Tobacco kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined. Approximately 1,700 Rhode Island adults die each year as a consequence of their own smoking. Approximately 23,000 children under 18 will ultimately die prematurely from smoking. Smoking tobacco is the major risk factor for lung cancer. In the United States, about 90% of lung cancer deaths in men and almost 80% of lung cancer deaths in women are due to smoking.

In recent years Rhode Island has made considerable progress in reducing smoking. Smoking by adults has decreased from 26% in 1990, 21% in 2004, 20% in 2005, to 19% in 2006. For high school students, the rate of those who have ever tried a cigarette has fallen from 69% in 1997 to 50% in 2003, while the rate of current smokers (those who smoked within the past 30 days) has fallen from 35% to 15.9%. The passage in 2005 of the state's smoke-free workplace law is expected to lead to additional declines in smoking among the state's inhabitants.

While smoking among Rhode Islanders has declined, not all population groups have benefited equally. Some populations experience disparate health impacts from tobacco, as a result of higher smoking rates, high youth initiation rates from targeted marketing by the tobacco industry, or because of other factors increasing the likelihood of members of these populations suffering negative health effects from firsthand or secondhand tobacco use.

The Rhode Island Department of Public Health (HEALTH) recognizes the need to address the health disparities and their impact from tobacco use. Funded by a grant from the federal Centers for Disease Control and Prevention (CDC), HEALTH convened a Workgroup of representatives of many of the diversely affected populations and organizations that serve these populations to develop a Rhode Island Strategic Plan to Address Tobacco-Related Health Disparities. This Workgroup met throughout the winter, spring, and summer of 2006. We here report on the work of this Workgroup and present the resultant Strategic Plan.

Background

The Centers for Disease Control and Prevention (CDC) is the lead federal agency for tobacco control efforts. The National Tobacco Control Program (NTCP) of the CDC has four goals:

- Eliminate exposure to environmental tobacco smoke,
- Promote quitting among adults and youth,
- Prevent initiation among youth, and
- Identify and eliminate disparities related to tobacco use among population groups.

Through the NTCP, CDC funds the states to develop and conduct programs that advance the NTCP goals. While substantial progress has been made toward achieving the first three goals, CDC became aware that progress lagged in achieving the fourth goal of identifying and eliminating tobacco-related disparities. While recognizing the existence of serious disparities in the impact of tobacco use, many states lacked the resources necessary to address this goal.

In response, CDC initiated grants to fund statewide strategic planning processes to develop comprehensive plans to address tobacco-related disparities. The intent is to give the state the resources and tools to bring together stakeholders involved with tobacco control and with disparately affected populations in a participatory planning process.

The first round of grants, funded in 2001, involved 13 states and United States territories. The second round, funded in 2005, involved 11 states, including Rhode Island.

Planning Workgroup

Upon award of the grant, two HEALTH programs, Tobacco Control and Minority Heath, agreed to collaborate in carrying out the project. A Planning Group was formed, which consisted of DOH staff from the two programs supplemented by an outside consultant and university-affiliated evaluation and technical assistance consultants.

The Planning Group developed criteria for a preliminary selection, based on tobacco use data, of disparately affected populations and for identifying community members to invite to join the Workgroup. Based on these criteria, the Planning Group recruited Workgroup members from those representing or working with groups that had been identified as being disparately affected by tobacco. Also included were voluntary associations, faith-based communities, health plans, and existing tobacco control programs.

The following groups/perspectives and organizations were represented on the Workgroup [In some cases, one organization represented two perspectives and is listed twice.]:

- **Voluntary Associations:** American Heart Association; American Lung Association; American Cancer Society
- **Mental Health:** The Kent Center; Department of Mental Health, Retardation & Hospitals
- **Youth Tobacco Enforcement**: Department of Mental Health, Retardation & Hospitals
- **Native American:** Pawtucket Substance Abuse Task Force
- **Low Income:** International Institute; Neighborhood Health Plan of RI
- **Health Plan:** Neighborhood Health Plan of RI
- **Substance Abuse Prevention:** Narragansett Youth Task Force, Department of Mental Health, Retardation & Hospitals
- **Disabilities:** RI Department of Health
- **13-17 Year Olds:** Narragansett Youth Task Force; RI Student Assistance Programs
- **18-24 Year Olds:** University of Rhode Island Student Health Services
- **Racial/Ethnic Minorities & Immigrants:** International Institute
- **Latinos:** Progreso Latino
- **African Americans:** John Hope Settlement House; RI Department of Health
- **Asian Americans:** Chinese Nurses' Association; Socio-Economic Development Center for Southeast Asians

Planning Process

The Strategic Plan was developed by the Workgroup through an eight-stage process:

1. Examine tobacco use data
2. Identify target populations
3. Conduct an environmental scan
4. Identify critical issues
5. Develop goals
6. Develop strategies, objectives and actions
7. Select the strategies to be addressed during the first year
8. Develop a plan to publicize the strategic plan

The Workgroup performed their work in seven day-long meetings. Between meetings the Planning Group conducted preparatory work for the next meeting including transcribing and editing the materials from the previous Workgroup session, preparing data for the workgroup to exam, conducting key informant interviews, and planning for the next Workgroup session.

All materials edited by the Planning Group were in turn brought back to the Workgroup for further refinement and final approval. Through their extensive preparatory efforts, the Planning Group sought to maximize the efficiency of the larger Workgroup and to reduce the demands upon Workgroup members by having as many tasks as possible not involving major decision-making carried out by staff and not by Workgroup members.

Data Examination

Data on tobacco use in Rhode Island was examined to identify those groups that were disparately affected. This data was collated from several surveys conducted by the state: Youth Tobacco Survey (YTS), Adult Tobacco Survey (ATS), Behavioral Risk Factor Surveillance System (BRFSS), the Health Interview Survey (HIS), the Youth Risk Behavior Survey (YRBS), and the Rhode Island Maternal and Child Health Database.

Key findings on smoking rates in Rhode Island:

- In Rhode Island, smoking by adults has been slightly but gradually decreasing in the past 14 years, from 26% (1990) to 21% (2004). (BRFSS 2004)
- Male Rhode Islanders are more likely to smoke (24%) than women (19%). (BRFSS 2004)
- Those 18-24 years old smoke at higher rates (28%) than do other adults. (BRFSS 2004)
- College graduates smoke at considerably lower rates (11%) than do those with less education, including those with a high school diploma or less education (27%) or those with some college who didn't graduate (26%). (BRFSS 2004)
- In 2002, 12% of pregnant women reported smoking during pregnancy. These rates were considerably higher for those aged 15-24 (19%) and for Native American women (34%). (RI Maternal and Child Health Database. Note: These data are provisional.)
- Those who are unemployed or unable to work smoke at elevated rates (37% and 34% respectively). (BRFSS 2004)
- Those adults with incomes below 200% of the Federal Poverty Level smoke over 50% more than those with incomes above that level (31% vs. 20%). (BRFSS 2004)
- Those without health insurance smoke at twice the rate of the insured (40% vs. 20%). The smoking rate for those on Medicaid (38%) is similar to that for the uninsured. (BRFSS 2004)
- Poor citizens and those with at most a high school education are less likely to have smoke-free homes than are others (poor: 61%, non-poor: 70%; HS education: 61%; >HS education: 73%). Children of poor Rhode Islanders are also more likely to be exposed to secondhand smoke in cars than their non-poor compatriots (20% vs. 12%). (BRFSS 2004 & HIS 2001)
- White smokers are more likely to be advised to quit by health professionals (80%) than are African-Americans (57%) or those of other race/ethnicity (72%: this category includes Hispanics and others). (BRFSS 2004)

In their first meeting, the Workgroup examined the data on tobacco use in Rhode Island, supplemented with selected data on use in other states and national data for certain groups where Rhode Island data was not available. [The data presentation is included as Appendix 1.] Out of this examination, the Workgroup identified 10 Rhode Island populations as being disparately affected by tobacco:

- Lesbian, Gay, Bisexual, Transgendered (LGBT)
- Poor (those with incomes less than 200% of the federal poverty level)
- Those with limited education
- Mentally ill
- Native Americans
- African-Americans
- Pregnant women
- Unemployed
- Uninsured
- Young people between the ages 18 - 24

Population Assessment

After the target groups were identified, the Planning Group conducted a Population Assessment consisting of 20 semi-structured key informant interviews with members of these groups to gather additional information. These interviews covered tobacco customs and attitudes, existing tobacco programs, what is currently being done in the community to address the tobacco problem, effective communication channels for reaching the population, community strengths, and community challenges.

This assessment resulted in identifying the following issues in these communities:

African Americans	[Only one interviewee on this population was reached within the 10-day period available. This informant spoke from the perspective of her church congregants and her responses could not be generalized.]
Lesbian, Gay, Bisexual, Transgendered (LGBT)	Smoking plays a central role in socialization, and many in the LGBT community are indifferent to tobacco control. AIDS and cancer have been the health focus in this community, and tobacco rarely gets their attention. Public health messages that are not culturally sensitive or not specifically geared toward this population may tend to be ignored. Currently no data on this population.
Low educational attainment	According to our interviewees, many in this population come from smoking households, resulting in intergenerational approval of tobacco. Literacy levels are generally low, which might interfere with the messages reaching them or with their attempt to receive information about health risks and treatment.
Mentally Ill	Tobacco use is seen and accepted as an important part of socialization, and therefore it is widely used by many clients to obtain approval by their peers. Also, many providers are reluctant to take tobacco products away from the clients due to the possible increase in psychiatric symptoms. The primary concern for mental health providers is to decrease psychiatric symptoms and promote recovery.
Native Americans	Tobacco is a sacred plant to Native Americans from the area of New England. Sacred tobacco is burned in ceremonies and utilized for other traditional purposes. Many Native Americans in Rhode Island have limited knowledge of the severe health effects of using tobacco commercially, and consequently they do not see smoking cessation as a priority for their community. This may be due to the limited communication channels to existing agencies/programs for the Native Americans, but also due to other problems in their community taking precedence. There is also a long history in these communities of distrust of outsiders, including state agencies, which led our informants to conclude that anti-smoking messages from Native American sources may be more effective. An additional complication is the differences between those living in urban communities; these groups tend to have distinct organizations and leaders.

Pregnant women	Some pregnant women quit smoking during pregnancy and return to smoking after giving birth; others, while aware of the harmful effects of tobacco, do not quit at all. These women are often exposed to secondhand smoke in their homes as well. Two subgroups of pregnant women were examined separately: young and Native American pregnant women. Both these populations are described as being especially passive towards tobacco and tending to ignore warnings about the negative health effects of tobacco use. Informants feel that there are not enough anti-smoking messages for pregnant women, since messages often get lost among all the other information they are receiving.
Unemployed	While unemployed individuals are aware of the health risks associated with smoking, they appear to be less concerned than their employed counterparts with its ill effects and with addressing it as a problem. The unemployed are focused on obtaining and retaining employment; tobacco is thus hardly seen as a priority. Also, their employment status has already put them under stress, which reduces their willingness to deal with smoking as an issue.
Uninsured	Because of the lack of insurance, the uninsured do not have regular access to health care or a regular primary care provider who could provide advice and information about health facts and treatment options. They are aware of the high cost of health problems associated with smoking and yet continue to smoke, which might be partially due to their lack of access to health care providers and other resources.
Young adults (18-24 years old)	Among this population, smoking is no longer seen as "cool," and the health risks of smoking are well acknowledged. These young people often claim that they are "social smokers" (i.e. smoke once in a while for socialization purposes) and believe that they can quit if they want to, largely denying the addictive potential of tobacco. Their social life is the number one priority for many. Thus, to the extent that smoking remains an important communal act, they will resist quitting.

[The Population Assessment Summaries by population are include as Appendix 2.]

Critical Issues

Integrating information from a variety of sources including the tobacco use data, the Population Assessment, and structured exercises designed to identify forces facilitating and interfering with tobacco control efforts in disparately affected communities, the Workgroup identified a number of Critical Issues facing efforts to reduce tobacco-related health disparities in Rhode Island. These Critical Issues fell into eight broad categories:

Category	Sample Critical Issues
Programming & Outreach	Need for emotional tie to tobacco control issues Need to address special needs of each population Lack of culturally appropriate tobacco control materials
The Social/Built Environment	Tobacco industry targeting of particular neighborhoods Sanitized image of tobacco industry
Strategic Partnering/Networks	The good reputation of the RI Tobacco Control Program The existence of other organizations, such as the Worksite Wellness Council of RI, the RI Prevention Alliance, and community health centers The small size of the state facilitates building alliances
Resource Constraints	Cuts in funding of tobacco control Limited funding for youth tobacco sales enforcement efforts
Legislation/Policy/Advocacy	Enactment of smokefree work legislation Low cost to obtain tobacco sales license Indoor advertising by tobacco industry at sales locations is court protected
Data	Language barriers to survey administration in certain communities Lack of data on various groups and need for specialized subgroup data collection
Interrelation of Social and Individual Factors Contributing to Tobacco Use	Fatigue with tobacco issues Use of tobacco as an aid to socializing Competing issues, e.g., unemployment, take precedence
Access and Delivery/Health care Systems	Importance of physicians and other health care providers Need to get physicians and other health care providers to routinely ask about tobacco use and need for billing mechanism Lack of continuity of insurance coverage

Note: Critical Issues includes strengths and successes as well as weaknesses and challenges

Strategic Plan

The Workgroup examined these Critical Issues and developed seven Goals for addressing them. For each Goal, several Strategies to accomplish the Goal were identified. These Goals and associated Strategies are:

GOAL 1. Identify the interrelationships between social, environmental, and individual factors contributing to tobacco use in order to develop and implement targeted programs

Strategy 1.1 *Create a new or integrate with an existing coalition bringing together those concerned with multiple health problems in order to address health disparities as a social justice issue.*

Strategy 1.2 *Collect information (qualitative and/or quantitative) on social and individual factors affecting tobacco use in disparately affected populations to increase effectiveness in programming and interventions.*

Strategy 1.3 *Develop and conduct a marketing campaign on social justice.*

GOAL 2. Identify and coordinate stakeholders to develop and enhance tobacco prevention and control initiatives within their disparately affected populations

Strategy: 2.1 *Identify organizations to help recruit key informants, stakeholders and potential partners from each of the disparately affected populations.*

Strategy: 2.2 *Educate stakeholders on tobacco issues related to their populations.*

Strategy 2.3 *Identify and educate legislative advocates for each population and bring them together with other "champions."*

GOAL 3. Create and enforce tobacco control policies

Strategy 3.1 *Increase restrictions and enforcement of restrictions on the sales and number of retailers of tobacco in municipalities representing disparately affected populations.*

Strategy 3.2 *Assure availability of evidence-based tobacco use cessation services to tobacco users in Rhode Island.*

Strategy 3.3 *Reduce tobacco industry influences.*

GOAL 4. Develop and implement comprehensive and innovative programming to eliminate tobacco use among disparately affected populations

Strategy 4.1 *Assure all programs are culturally and linguistically appropriate, for example, programs appropriate for those with low literacy.*

Strategy 4.2 *Conduct workforce development sessions and work with existing certification process to educate personnel of agencies and organizations who work with identified disparately affected populations on eliminating tobacco use.*

Strategy 4.3 *Raise awareness and involvement on the issue of tobacco use among disparately affected populations.*

Strategy 4.4 *Affect systems change regarding smoking and socializing among disparately affected populations.*

GOAL 5. Improve the effectiveness of the health care system as a channel to promote tobacco control and prevention

Strategy 5.1 *Advocate that insurance companies provide coverage for prevention and intervention for tobacco treatment for disparately affected populations.*

Strategy 5.2 *Support and expand accessible tobacco control service delivery to communities with disparately affected populations (e.g. new locations for mobile teams could include pharmacies and supermarkets)*

Strategy 5.3 *Increase involvement of medical professionals and allied health care providers in providing tobacco control services to disparately affected populations.*

Strategy: 5.4 *Advocate that curriculum at medical and allied health professional schools require a class on health disparities, including tobacco use prevention and control Classes should include information on the causes of health disparities as well as how to eliminate disparities*

GOAL 6. Identify funding and address resource constraints

Strategy *6.1* *Identify needs and cost of implementing this disparities strategic plan.*

Strategy 6.2 *Create an advocacy structure together with the new coalition and the Department of Health to increase funding for tobacco prevention and control with disparately affected populations.*

Strategy 6. 3 *Allocate staffing support to help implement the plan.*

GOAL 7. Identify and clarify data needs, as well as appropriate sources and methods to obtain them

Strategy: 7.1 *Evaluate current methods of data collection (qualitative and quantitative) in terms of their ability to obtain needed information on disparately affected populations. Use evaluation criteria such as: Do they ask the right questions? Are they culturally and linguistically sensitive? Are they geographically representative? Do they utilize trusted stakeholders to poll specific populations?*

Strategy: 7.2 *Increase the quality and quantity of data collected on disparately affected populations*

The Workgroup further identified Objectives and Actions for each Strategy. The complete plan with all the Objectives and Actions is included as Appendix 3.

Priorities

The Workgroup recognized that not all the activities envisioned in the Strategic Plan could be accomplished immediately. The group selected six Strategies as priorities to be addressed during the first year of the Plan. These Strategies, with their associated Objectives and Actions are:

Strategy 1.1 *Create a new or integrate with an existing coalition bringing together those concerned with multiple health problems in order to address health disparities as a social justice issue.* [**Associated Goal 1:** Identify the interrelationships between social, environmental, and individual factors contributing to tobacco use in order to develop and implement targeted programs]

Workgroup members felt that a promising approach would be to approach health disparities as a social justice issue[1]. Such an approach can tie together a range of health issues while energizing communities to tackle these disparities. In order to be effective, these efforts need to bring together advocates for different health issues to combine forces to eliminate health disparities. The Workgroup decided that forming or joining an existing coalition of those addressing health disparities as a social justice issue was a key element of the overall strategy. They identified the following Objective and Actions to initiate the process:

Objective 1.1.1. Identify other coalitions working with disparately affected populations and consider joining their initiative. If no existing coalition is identified, identify and recruit other organizations and issues that can join with tobacco control advocates, i.e. obesity, chronic disease, or diabetes.

Action a: Identify existing HEALTH or community-based coalitions.

Action b: If no suitable existing coalition is identified, develop a recruitment plan for a new coalition.

Action c: Create a list of targeted organizations and agencies.

Action d: Recruit and convene key stakeholders and decision-makers from the targeted organizations and agencies.

Strategy: 2.1 *Identify organizations to help recruit key informants, stakeholders and potential partners from each of the disparately affected populations.* [**Associated Goal 2:** Identify and coordinate stakeholders to develop and enhance tobacco prevention and control initiatives within their disparately affected populations.]

The Workgroup decided that in order to successfully address tobacco-related health disparities, it was necessary to involve as partners stakeholders from each of the disparately-effected communities and those working with these communities. Potential partners should include a wide range of people, including members of each of the identified populations, senior staff at organizations working with these populations, and health plans among others. For the first year, the Workgroup decided that a priority was the identification and recruitment of key informants, stakeholders and partners from each of the identified disparately-effected communities. They identified the following Objective and Actions to accomplish this Strategy:

Objective 2.1.1. Identify common ground/interests between disparately affected populations/communities and advocates for tobacco control and improved health and health care services.

Action a: Use the staff discussed in Strategy 6.3 for staffing support.

Action b: Talk to someone at Crossroads of RI to gather information about other collaborating agencies/resources (e.g. using their Blue Book).

Action c: Get recommendations from the Department of Health and other state agencies (e.g. HEALTH, DHHS, DEA, MHRH, DCYF, DOE, etc.) to identify key informants.

Action d: Contact local government offices for recruitment of key informants.

Action e: Contact the organizations listed in the chart developed by this group entitled "Organizations that could partner or connect us with disparately affected populations in tobacco use".

Action f: Involve insurance companies (e.g. United Healthcare, Neighborhood Health Plan of RI, Blue Cross/Blue Shield of RI).

Strategy 3.1 *Increase restrictions and enforcement of restrictions on the sales and number of retailers of tobacco in municipalities representing disparately affected populations.* [**Associated Goal:** Create and enforce tobacco control policies]

The Workgroup felt that enacting and enforcing tobacco control policies is one of the most effective approaches to reduce smoking. They were very concerned about the prevalence of sales venues including convenience stores, gas stations and vending machines in disparately-affected communities. In particular, inadequately supervised vending machines allow young people, who cannot legally purchase cigarettes, to obtain them. The Workgroup therefore gave priority to working with municipalities to enact and enforce regulations reducing the number of retailers of tobacco. As a first step, the Workgroup proposed banning vending machine tobacco sales in locations that are accessible to young people. The specific Objective and Actions they identified to accomplish this Strategy are:

Objective 3.1.1. Increase the proportion of municipalities with policies that ban tobacco vending machine sales in places accessible to young people in communities where disparately affected populations live.

Action a: Survey vending machines in geographic areas where disparately affected populations live in order to determine extent of compliance with existing vending machine regulations.

Action b: Examine existing state and local laws and legal decisions in order to determine what types of regulation are currently allowed.

Action c: Identify elected officials and/or their staff members to champion the desired tobacco control policy changes.

Action d: Educate and mobilize communities.

Action e: Conduct media advocacy.

Strategy 3.2 *Assure availability of evidence-based tobacco use cessation services to tobacco users in Rhode Island.* [**Associated Goal:** Create and enforce tobacco control policies]

Tobacco control efforts aim to prevent tobacco use and help current smokers quit, i.e., at facilitating tobacco cessation. Research shows that tobacco cessation services are effective. Yet, it has often been difficult or impossible to get insurance coverage for these services. While the Workgroup was developing the Strategic Plan, the legislature passed mandated tobacco cessation coverage in all of Rhode Island's health insurance plans. This mandate was strongly welcomed by the Workgroup.

However, the Census Bureau estimates over 11% of Rhode Islanders do not have medical insurance. The populations that are disparately affected by tobacco often have high rates of not being insured. In anticipation of the budget cuts to the tobacco control program in Fiscal Year 2007, which included all funding for publicly provided smoking cessation programs, the General Assembly passed the insurance mandate to help alleviate the impact of these cuts. The Workgroup felt that it was critical for the state to adequately fund accessible cessation services for our uninsured citizens. The following Objective and associated Action were identified:

Objective 3.2.1. Fund tobacco cessation services for uninsured Rhode Islanders.

Action a: Develop a mechanism to provide cessation services to the uninsured.

Strategy 4.1 *Assure all programs are culturally and linguistically appropriate, for example, programs appropriate for those with low literacy.* [**Associated Goal:** Develop and implement comprehensive and innovative programming to eliminate tobacco use among disparately affected populations.]

Existing tobacco control programs sometimes find it difficult to reach disparately affected populations, as they may not be sensitive to those populations' particular cultural or linguistic issues. Materials may not be available in these groups' languages, or may require too high a reading level. These materials may not use the cultural symbols most likely to motivate a group or may even use language that a group is likely to find objectionable.

The Workgroup prioritized addressing this issue. They felt that all the state's tobacco control programs should take steps to be appropriate for the populations they serve. The Workgroup felt it was important to identify programs and models that are effective with the particular identified populations, and to train all Rhode Island programs providing tobacco services in the use of these programs and models. They identified two Objectives and associated Actions to accomplish this Strategy:

Objective 4.1.1. Identify existing tobacco control programs and models that are successfully working with disparately affected populations.

Action a: HEALTH develops a list of tobacco control programs, strategies, best practices and models for the various disparately affected populations.

Action b: HEALTH provides the Governor and his advisory committee with key contacts and programs related to tobacco control in the state.

Objective 4.1.2. Deliver technical assistance and training to organizations working with disparately affected populations to help them utilize culturally and linguistically appropriate programs.

Action a: Develop a sub-committee made up of HEALTH staff and personnel from disparately affected populations to develop and review plans.

Action b: Establish a sub-committee and train the committee to seek and identify resources and possibly to deliver them.

Strategy: 7.2 *Increase the quality and quantity of data collected on disparately affected populations.* [**Associated Goal:** Identify and clarify data needs, as well as appropriate sources and methods to obtain them.]

In order to address health disparities, timely data is essential to identify which populations are experiencing disparate impacts and to spot newly emerging problems. Several issues interfere with obtaining adequate data on many populations: state surveys often do not adequately sample smaller subpopulations; data collectors may not speak certain languages; and groups may not be identified if data collection instruments do not ask appropriate questions.

The Workgroup felt that initiatives to eliminate disparities require accurate, timely data on tobacco use among disparate populations. They felt it was a priority to improve the state's data collection systems to collect such data. The Workgroup identified the following Actions to accomplish this Strategy:

Action a: Identify who is collecting and using data on disparately affected populations.

Action b: Collect the data on an annual basis.

Action c: Identify the gaps in and barriers to data collection.

Action d: Encourage the inclusion of sexual orientation in state prevalence and risk factor surveys.

Action e: Encourage researchers to include tobacco-related questions for disparately affected populations.

Action f: Require Comprehensive Tobacco Control Programs [CTCs] to gather data through community events and programs.

[The implementation plan for the year one priorities is attached as Appendix 4.]

Evaluation

RI HEALTH contracted with an external evaluator to conduct the CDC-mandated Case Study evaluation of the development of the strategic plan. The evaluator also assessed each of the workgroup planning meetings as to participant satisfaction with the group process, strengths/weaknesses, possible improvements, quality of facilities and of staff support, ease of participation, and accomplishments. Evaluation findings were given back to the Workgroup on a consistent basis.

HEALTH will evaluate Plan implementation and describe annual progress, as well as any accomplishments and/or barriers faced during implementation and will employ diverse data collection methods such as key informant interviews, telephone surveys, and document review as needed. Lastly, annual recommendations for how well the plan was implemented may come from stakeholders actively involved in carrying out the plan, and these recommendations will be included in the evaluation.

Since Rhode Island has both a small population (less than 1.5 million) and a small minority population (less than 18%), identifying alternative data sources for groups disproportionately affected by tobacco is necessary for targeting interventions, allocating resources to bridge the health disparities gap and assessing change. An evaluation sub-committee will evaluate current methods of data collection (qualitative and quantitative) at state and community level in terms of their ability to obtain needed information on disparately affected populations and recommend improvements when necessary. Modeling techniques and combining samples over several years may allow for more stable estimates for populations that have little or no existing data or when sample sizes are too small to allow generalization to the population. Reducing disparities related to tobacco is a collaborative effort that will involve disseminating the results of this evaluation to other stakeholders who share an interest in working on this important objective, so that the evaluation can inform and improve efforts to reduced disparities in the state.

Agencies that Participated in the Disparities Strategic Planning Process

American Cancer Society

American Heart Association - Northeast Affiliate

American Lung Association of Rhode Island

Chinese Nurse Association of America

Crossroads of Rhode Island

Disparities Strategic Planning Process Facilitator

Interim Church Administrator, Open Table of Christ UMC

International Institute of Rhode Island

John Hope Settlement House

Minority Health Promotion Center

Narragansett Youth Task Force

Neighborhood Health Plan of Rhode Island

Pawtucket Substance Abuse Prevention Task Force

Progreso Latino

Rhode Island Department of Health, Office of Disabled Persons

Rhode Island Department of Health, Office of Minority Health

Rhode Island Department of Health, Tobacco Control Program

Rhode Island Department of Mental Health, Retardation and Hospitals

Rhode Island Employee Assistance Services

Rhode Island Health Center Association

RI Department of Health, Office of Communications/Media

Socio-Economic Development Center for Southeast Asians

The Kent Center of Warwick Rhode Island

University of Rhode Island, Health Services

University of Rhode Island, Tobacco Control Enhancement Project

Urban League of Rhode Island

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Copies of the Disparities Strategic Plan are available from:

Rhode Island Department of Health

Tobacco Control Program

3 Capitol Hill, Room 409
Providence, RI 02908
Phone: 401-222-7630
E-mail: Kelly.Doyle@health.ri.gov
http://www.health.ri.gov/tobacco/disparities.php

(Footnotes)

[1] As an example, some states have had success at bringing the anti-tobacco message to the Lesbian, Gay, Transgendered, and Bisexual community by focusing on the tobacco industry's targeted marketing toward that community.

Appendix A

Tobacco Disparities Workgroup Data

DATA SOURCES

BRFSS Behavioral Risk Factor Surveillance System
- Administered by phone annually
- English, Spanish, Portuguese

HIS Health Interview Survey
- RI version administered 2001, 2003

YRBS Youth Risk Behavior Survey
- Administered in a sample of public high schools biennially
- Data from 1997, 2001, and 2003; Insufficient data in 1999

ATS Adult Tobacco Survey
- Administered in 2003 to persons at least 18 years old

YTS Youth Tobacco Survey
- Sample middle school (6-8) & high school (9-12) students
- Administered in 2001 and planned biennially thereafter

Tobacco-related Morbidity & Mortality

Tobacco-related Morbidity

- Cancers: Lung, mouth, throat, bladder, pancreas, kidneys, and cervix
- Increases risk of heart disease, strokes, induced asthma, complicated diabetes, duodenal and gastric ulcers, birth of low-weight babies
- Causes respiratory symptoms such as cough, sputum production, and wheezing

Tobacco-related Deaths in Rhode Island

- Adults who die each year from their own smoking: **1,700**
- Kids now under 18 and alive in Rhode Island who will ultimately die prematurely from smoking: **23,000**
- Adults, children, & babies who die each year from others' smoking (secondhand smoke & pregnancy smoking): **140 to 260**

Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined

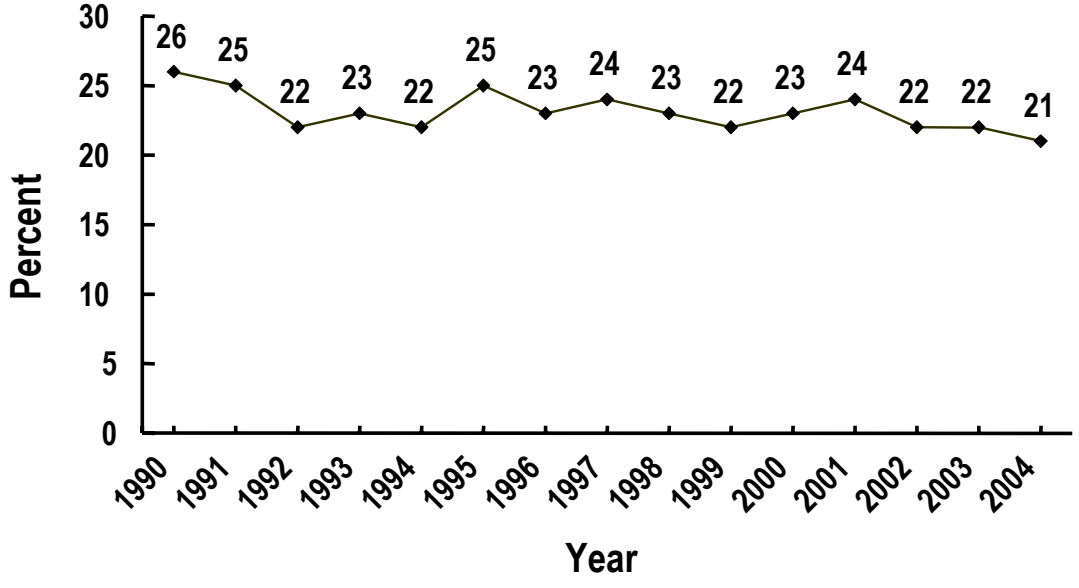
Healthy People 2010 Tobacco Use Health Indicators

Leading Health Indicators Objectives	Baseline US	US Target	Baseline RI	RI Target
27.1 Reduce cigarette smoking by adults	24%	12%	23%[1]	10%
27.2 Reduce cigarette smoking by adolescents	35%	16%	35%[2]	16%

1: RI BRFSS, 2000
2: RI YRBS, 2000

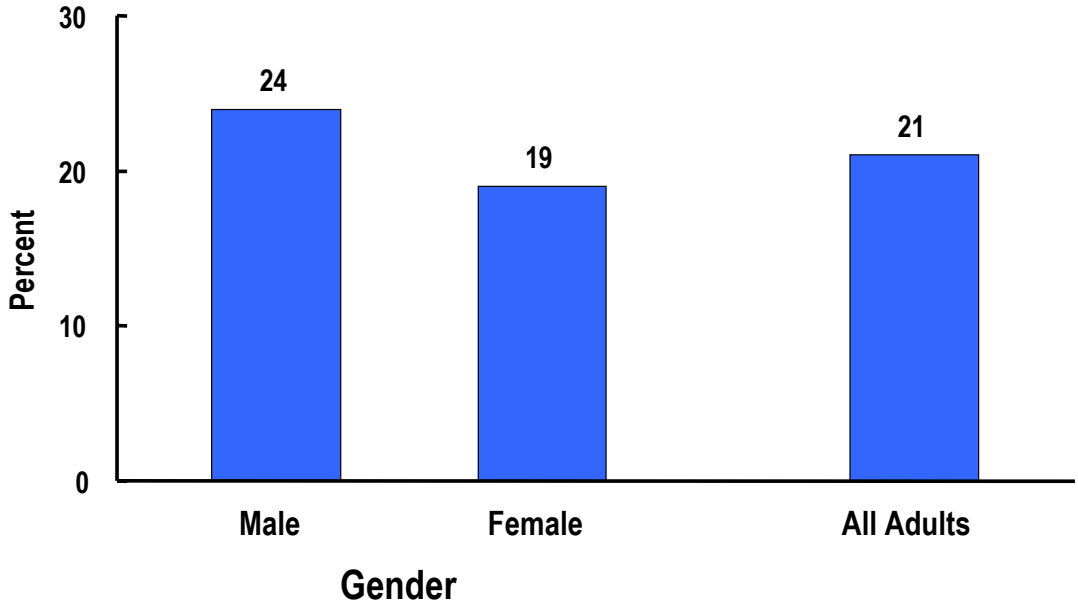
Adult Smoking

% RI Adults who Smoke by Year, 1990-2004



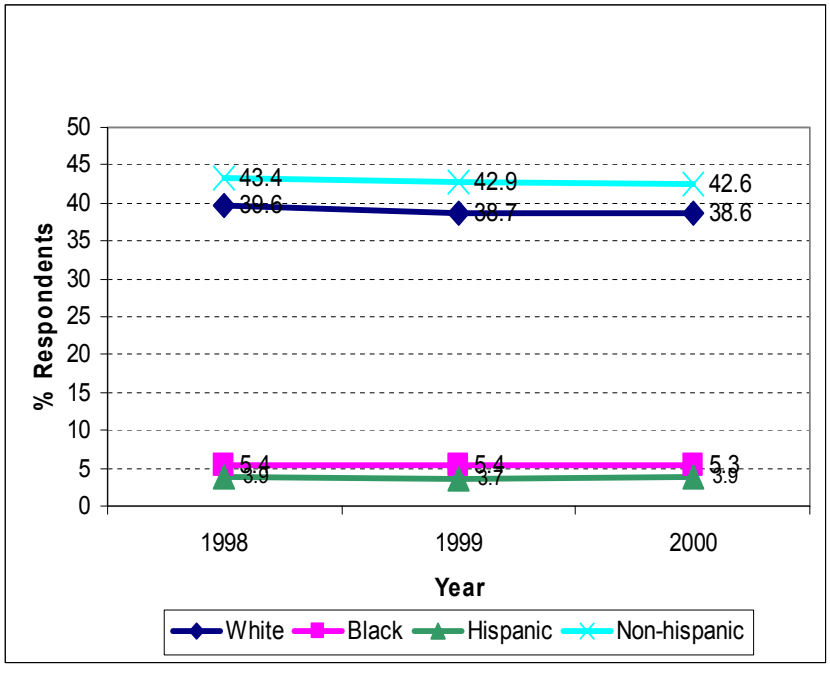
RI BRFSS, 2004

% Adults Who Smoke by Gender, 2004



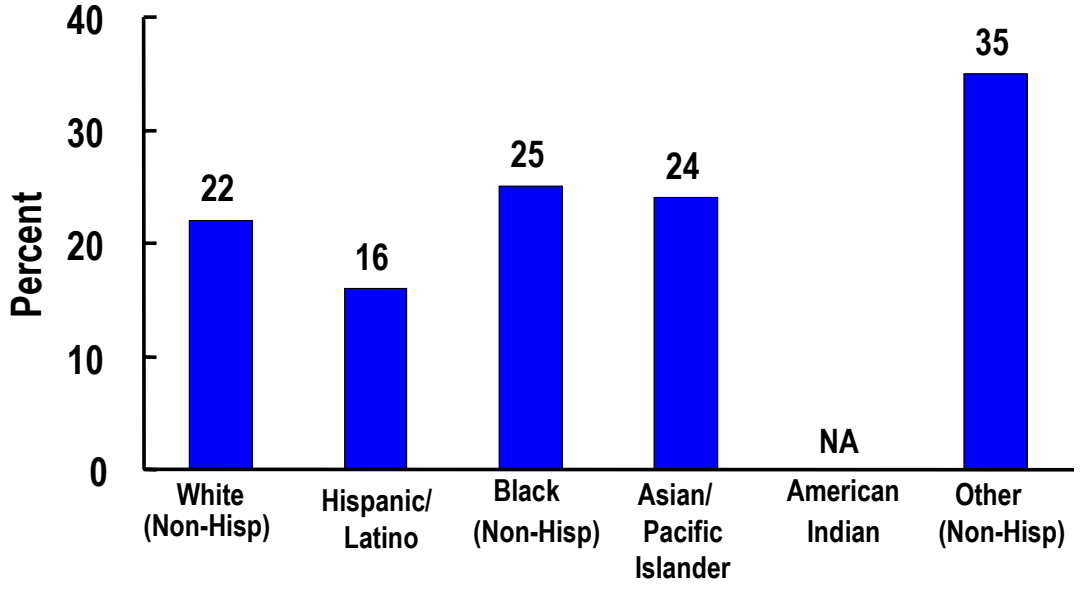
RI BRFSS, 2004

US Smoking Trends by Race/Ethnicity



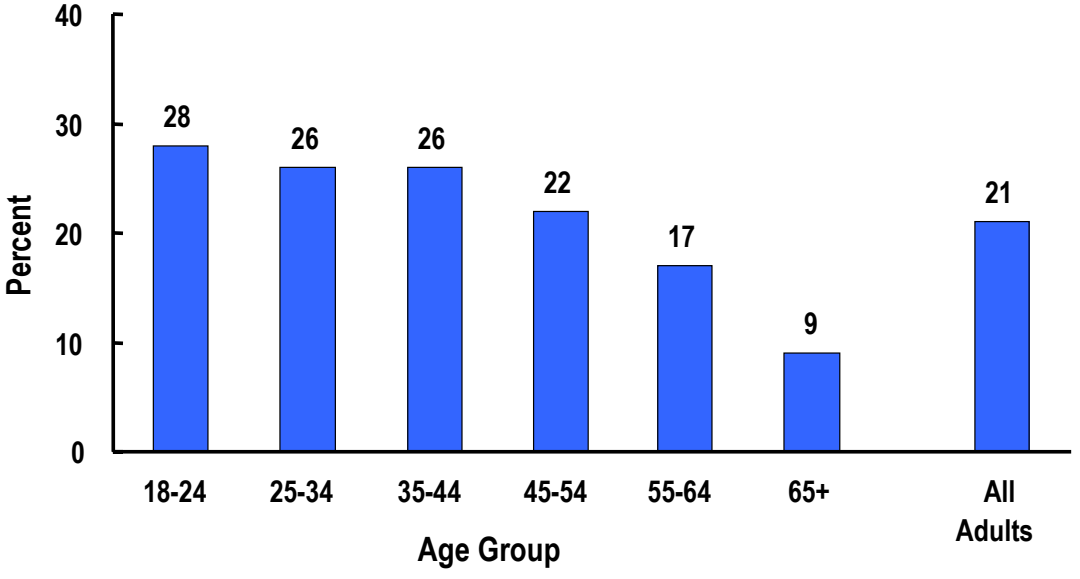
NHIS 1998-2000

% RI Adults Who Smoke by Race/Ethnicity, 2002-2004



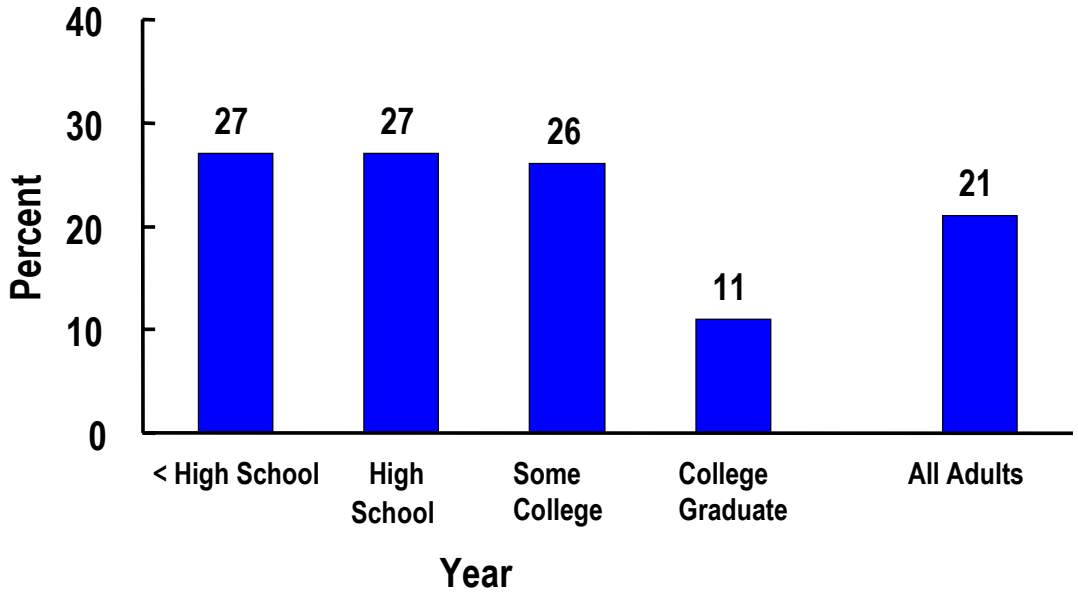
RI BRFSS, 2002-04

% Adults Who Smoke by Age, 2004



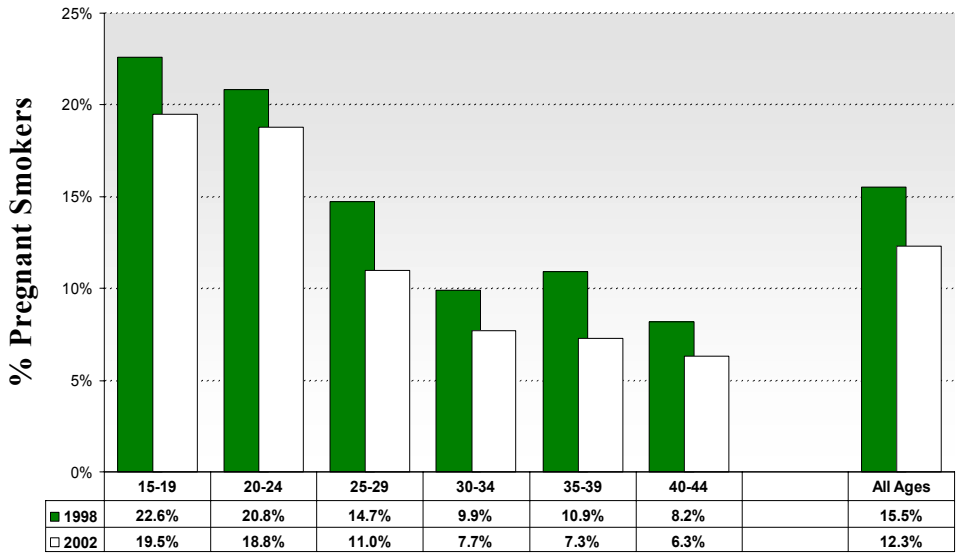
RI BRFSS, 2004

% Adults Who Smoke by Education, 2004



RI BRFSS, 2004

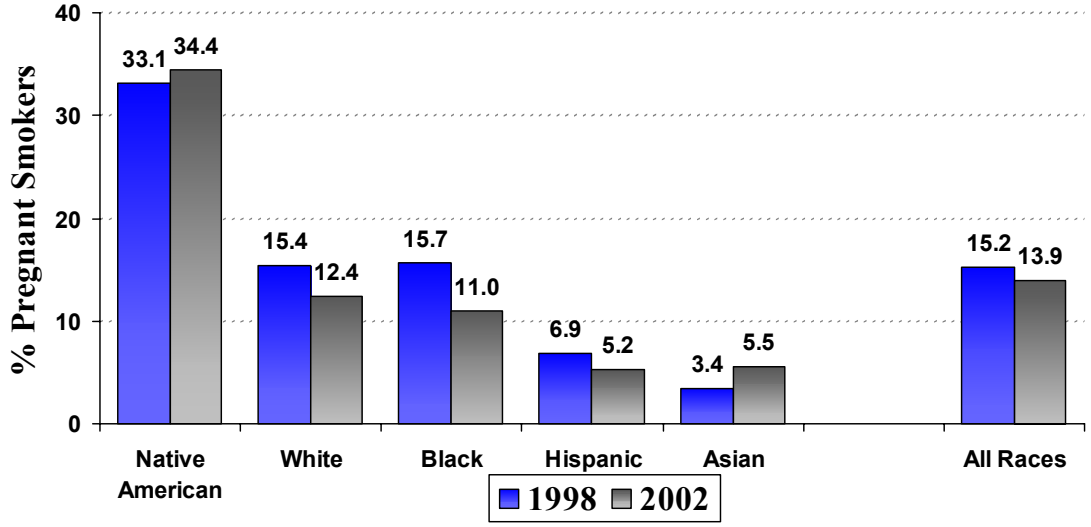
Smoking During Pregnancy by Age: RI



	15-19	20-24	25-29	30-34	35-39	40-44		All Ages
1998	22.6%	20.8%	14.7%	9.9%	10.9%	8.2%		15.5%
2002	19.5%	18.8%	11.0%	7.7%	7.3%	6.3%		12.3%

Source: Maternal and Child Health Database: Division of Family Health, Rhode Island Department of Health

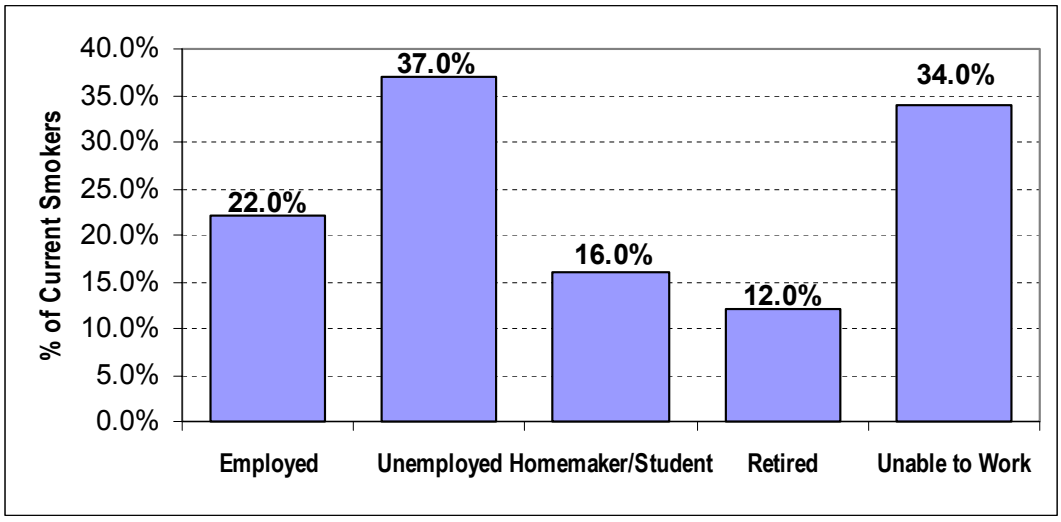
Smoking During Pregnancy by Race/Ethnicity: RI



Note: 2000-2002 data are provisional

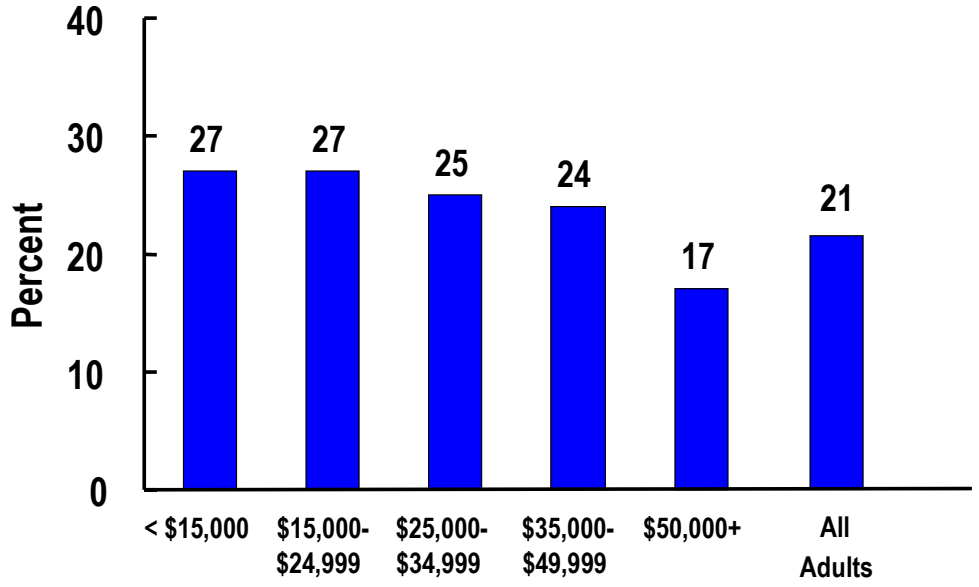
Source: Maternal and Child Health Database, Division of Family Health, Rhode Island Department of Health

RI Current Smokers Classified by Employment Status



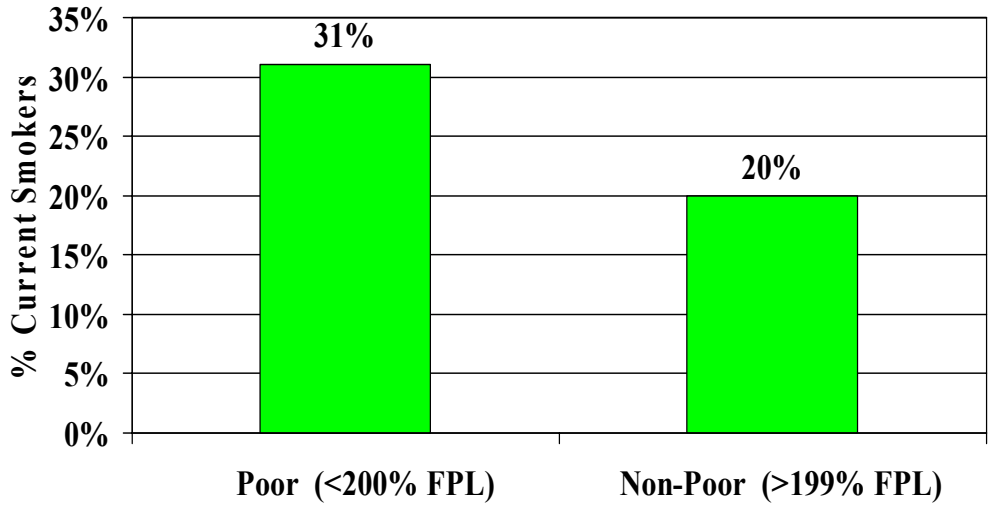
RI BRFSS, 2004

% Adults Who Smoke by Household Income, 2004



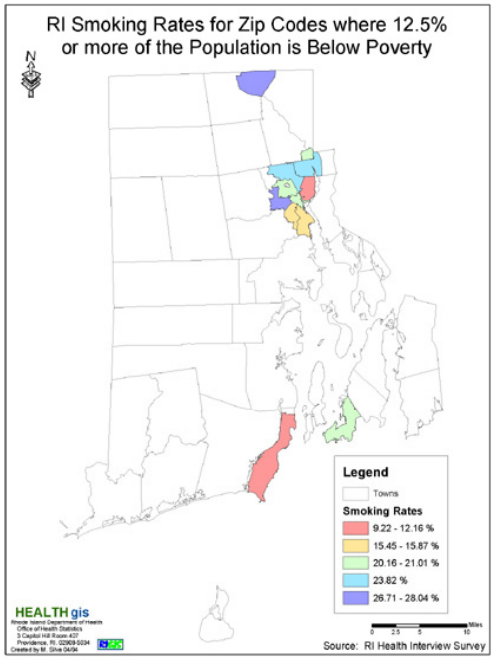
RI BRFSS, 2004

Current Smokers Classified by Poverty Status

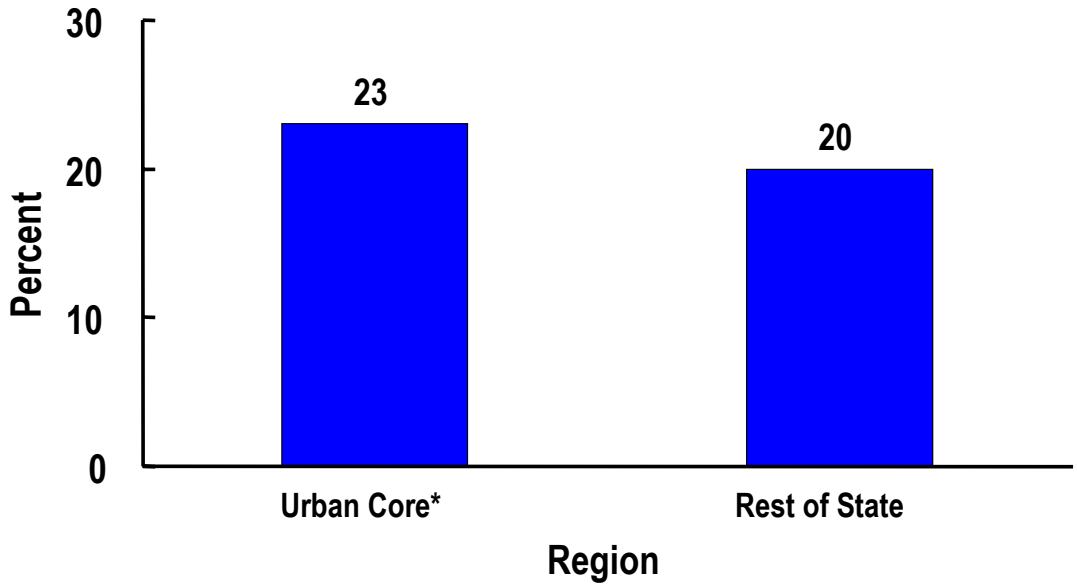


RI BRFSS, 2002


Rhode Island Census Tracts with 12.5% or more of the Population Below the Poverty Level
N
Woonsocket
Burrillville
North Smithfield
Cumberland
Central Falls
Smithfield
Lincoln
Pawtucket
Glocester
North Providence
Providence
Johnston
East Providence
Foster
Scituate
Barrington
Cranston
Warren
Warwick
Coventry
West Warwick
Bristol
East Greenwich
West Greenwich
Exeter
Tiverton
North Kingstown
Little Compton
Hopkinton
Richmond
South Kingstown
Portsmouth
Jamestown
Middletown
Newport
Charlestown
Narragansett
Westerly
New Shoreham
Legend
12.5% of Pop. Below Poverty
Town Boundaries
HEALTH gis
Miles

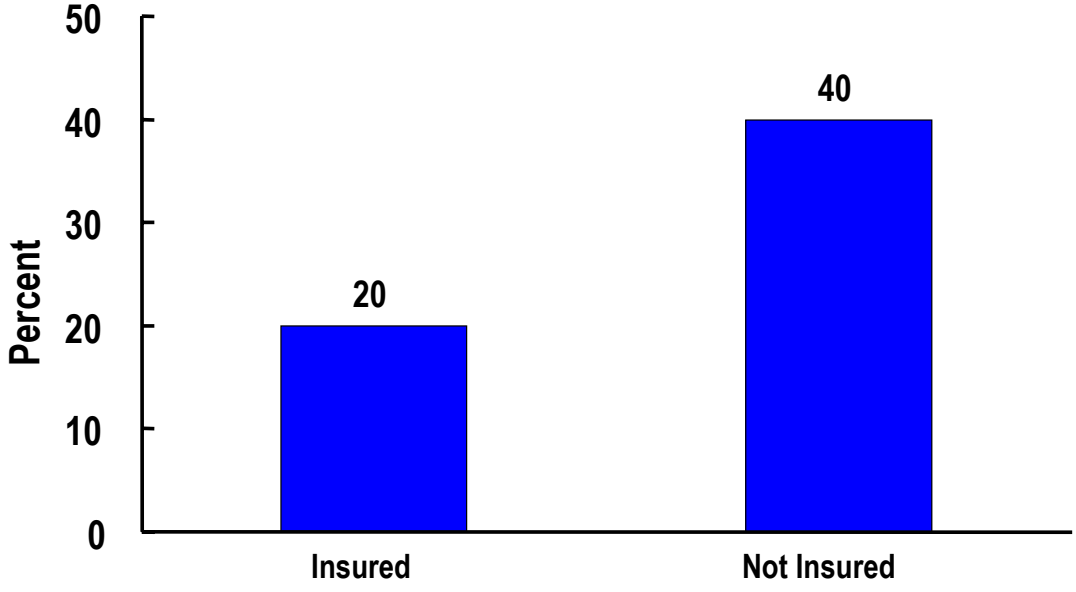

RI Smoking Rates for Zip Codes where 12.5% or more of the Population is Below Poverty
N
Legend
Towns
Smoking Rates
9.22 - 12.16 %
15.45 - 15.87 %
20.16 - 21.01 %
23.82 %
26.71 - 28.04 %
HEALTH gis
Miles
Source: RI Health Interview Survey

% Adults Who Smoke by Region, 2004



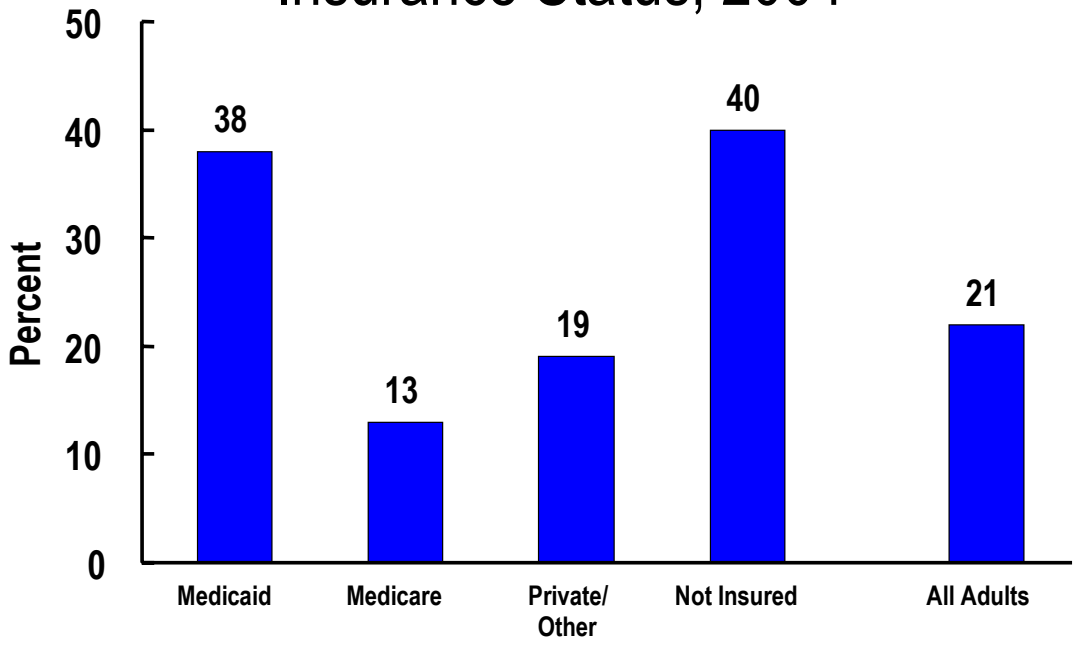
* Urban Core: Providence, Pawtucket, Central Falls, Woonsocket, Newport, West Warwick

% Adults Who Smoke by Health Insurance Status, 2004



RI BRFSS, 2004

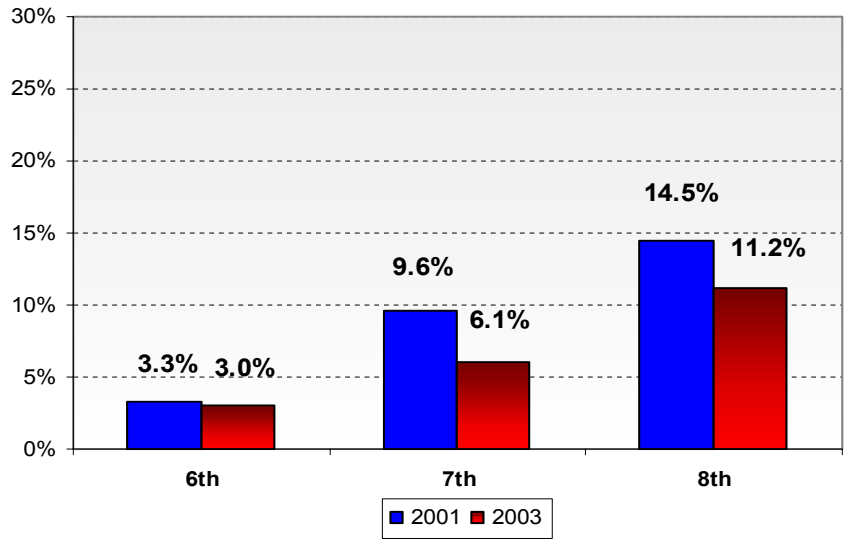
% Adults Who Smoke by Health Insurance Status, 2004



RI BRFSS, 2004

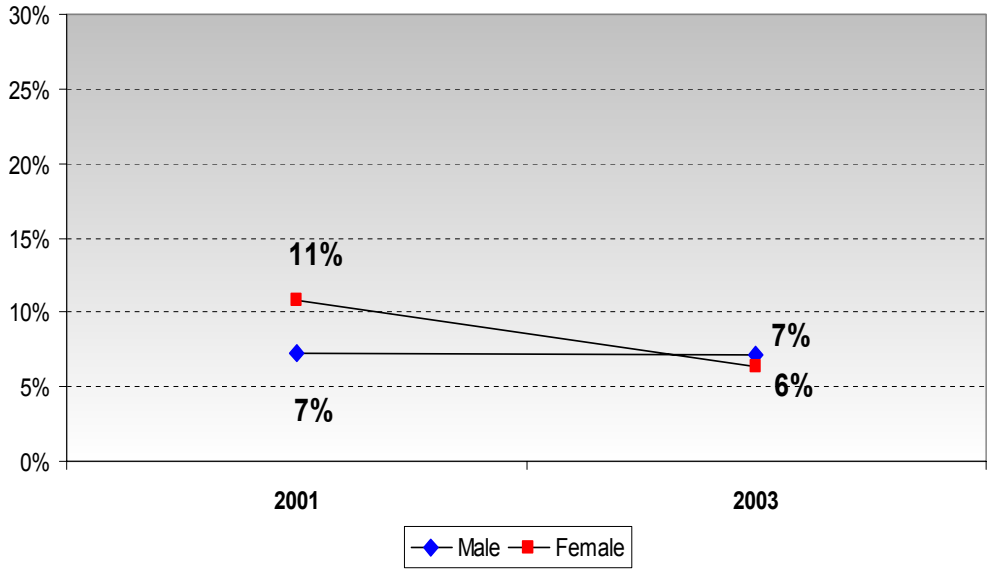
Youth Initiation

% RI Public Middle School Students who are Current Smokers* by Grade: 2001 & 2003



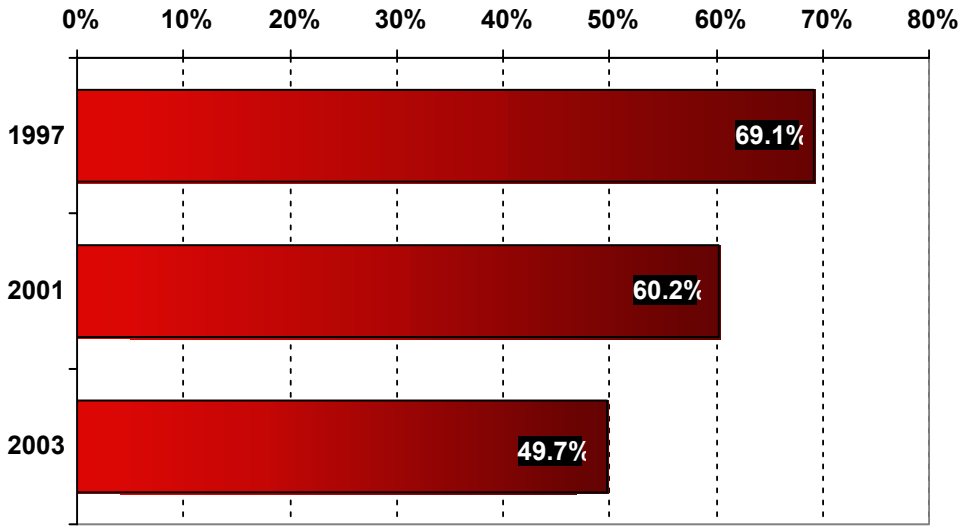
*Smoked one or more cigarettes during the past 30 days.
RI YTS: 2001 and 2003

% RI Public Middle School Students who are Current Smokers* by Gender: 2001 and 2003



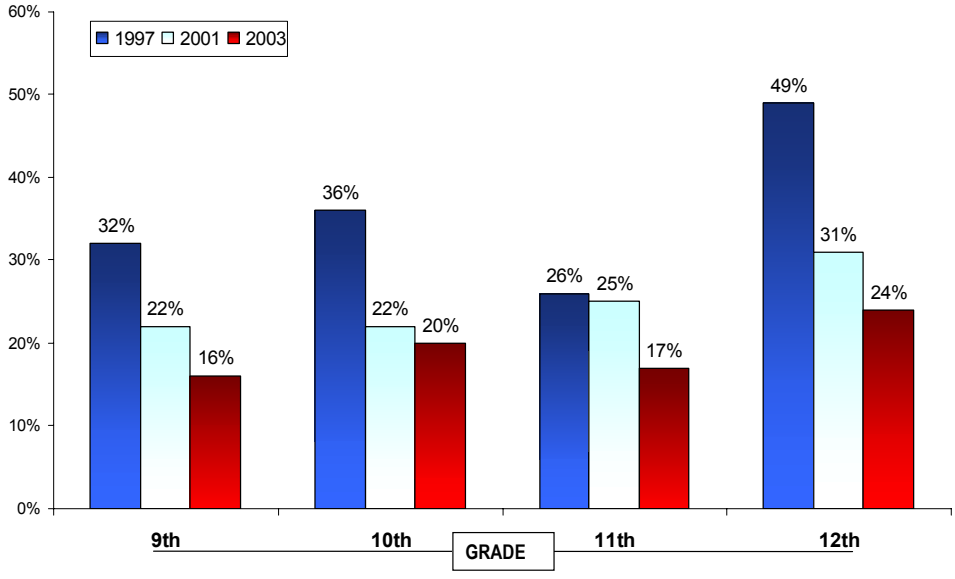
*Smoked one or more cigarettes during the past 30 days.
RI YTS: 2001 and 2003

RI Public High School Students Who Ever Tried Cigarette Smoking: 1997, 2001, and 2003

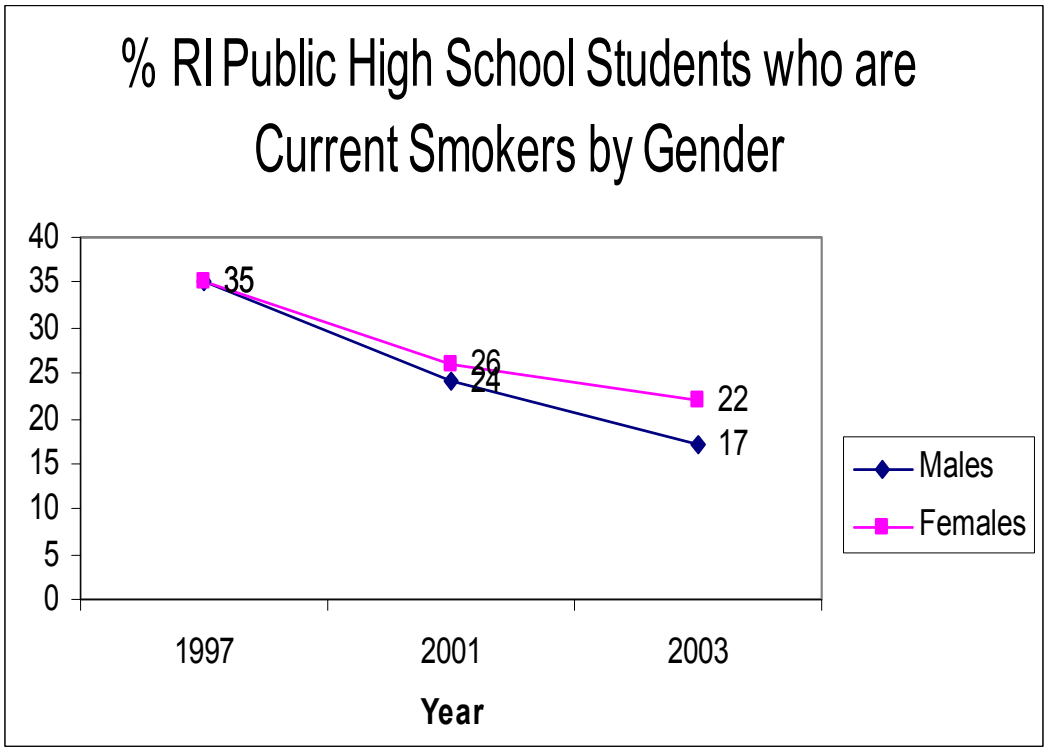


*Smoked one or more cigarettes during the past 30 days.
RI YRBS: 1997, 2001, 2003

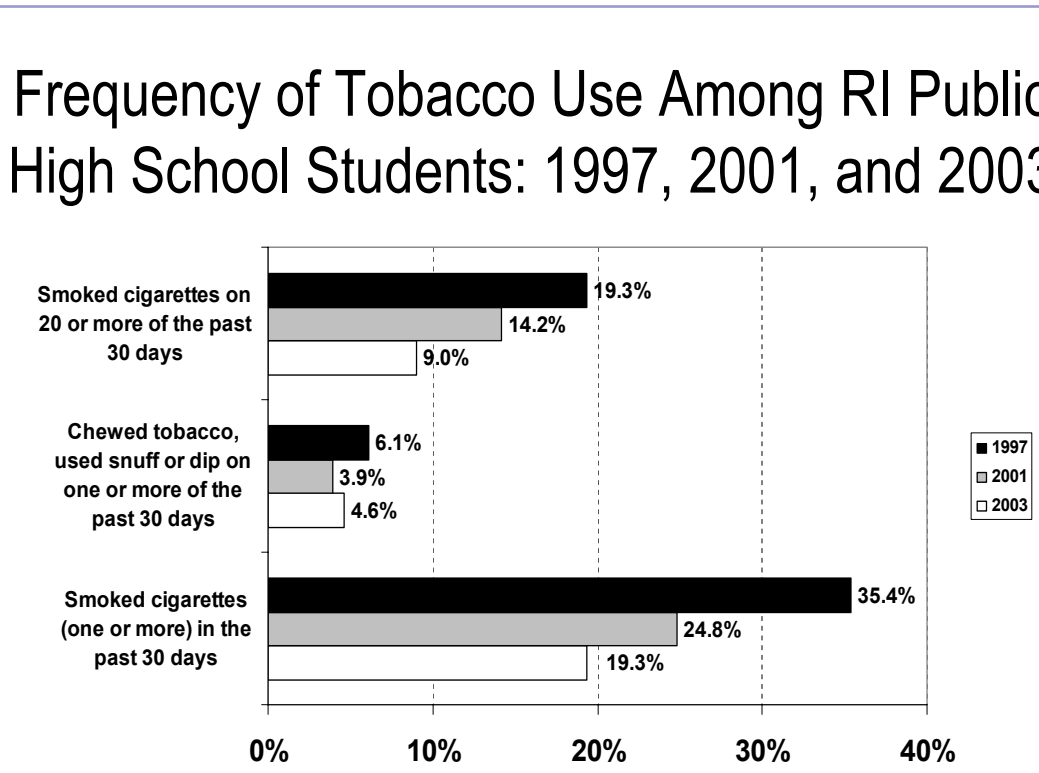
% RI Public High School Students who are Current Smokers* by Grade: 1997, 2001, and 2003



*Smoked one or more cigarettes during the past 30 days.
RI YRBS: 1997, 2001, 2003

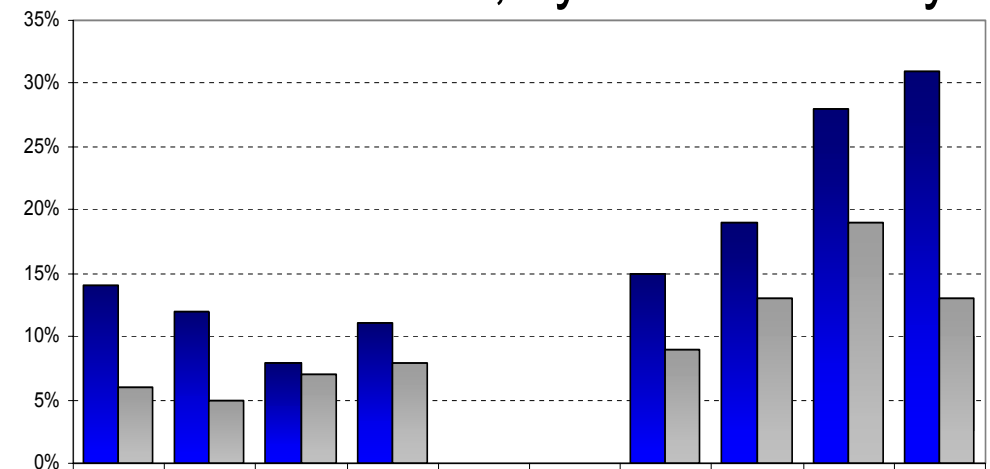


*Smoked one or more cigarettes during the past 30 days.
RI YRBS: 1997, 2001, 2003



RI YRBS: 1997, 2001, 2003

RI Public School Students who are Current Smokers, by Race/Ethnicity



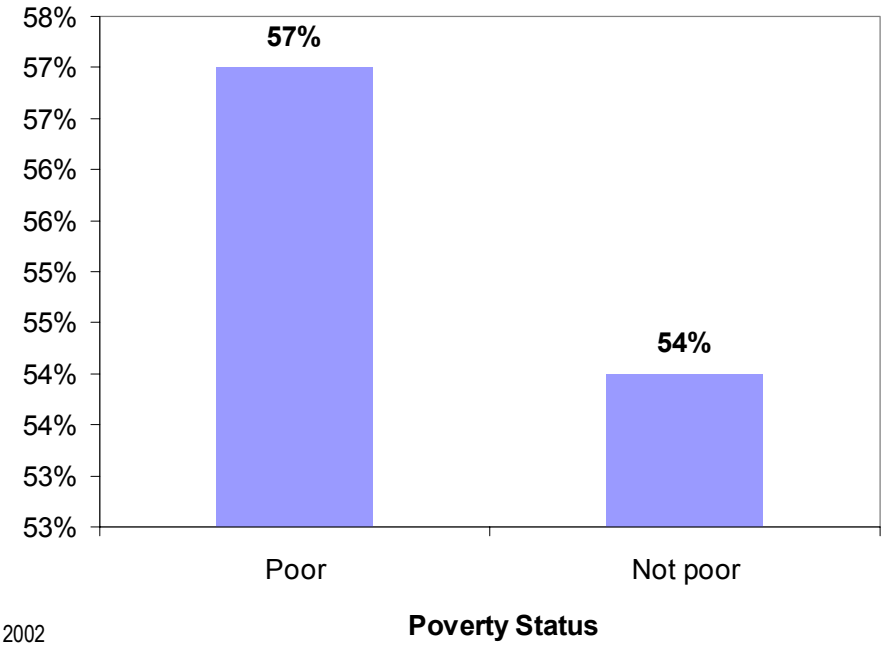
	Black	Hispanic	White	Other			Black	Hispanic	White	Other
2001	14%	12%	8%	11%			15%	19%	28%	31%
2003	6%	5%	7%	8%			9%	13%	19%	13%

Middle School

High School

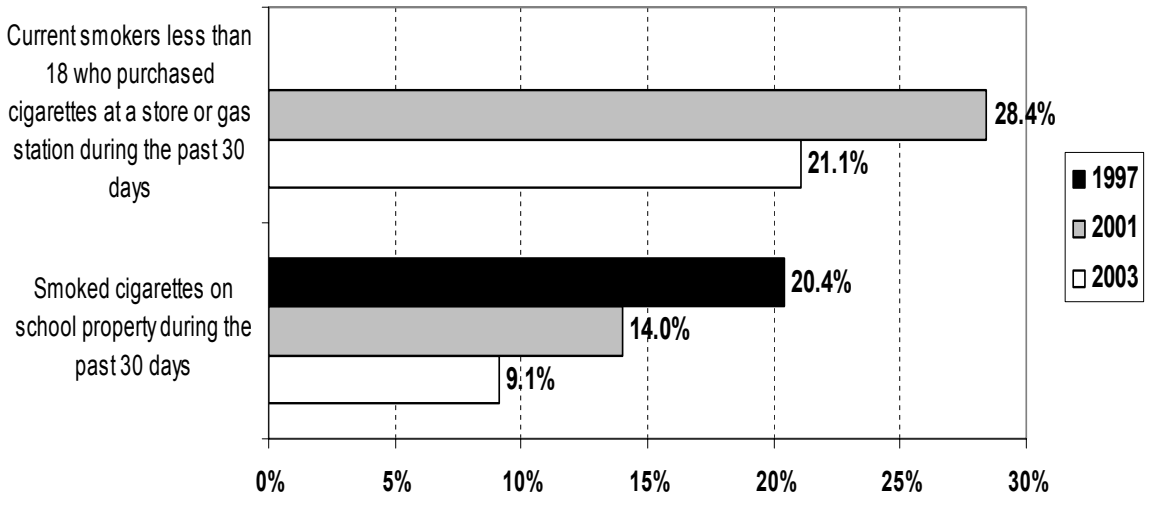
Source ?

Youth who Initiated Smoking Before Age 18, Classified by Poverty Status



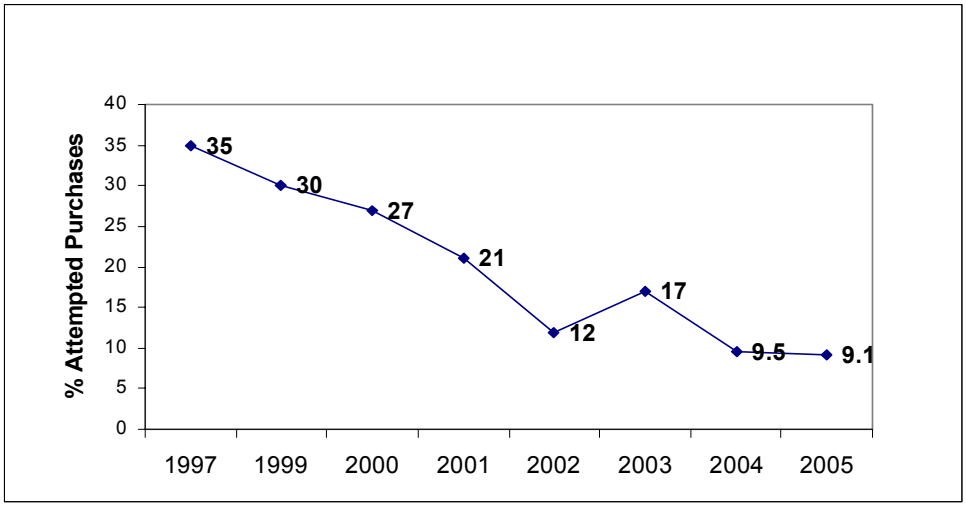
BRFSS, 2002

Source and Site of Smoking Among Public High School Students: 1997, 2001, and 2003



RI YRBS: 1997, 2001, 2003

% Attempted Purchases in which RI Retailers Would Sell Cigarettes to Underage Youth

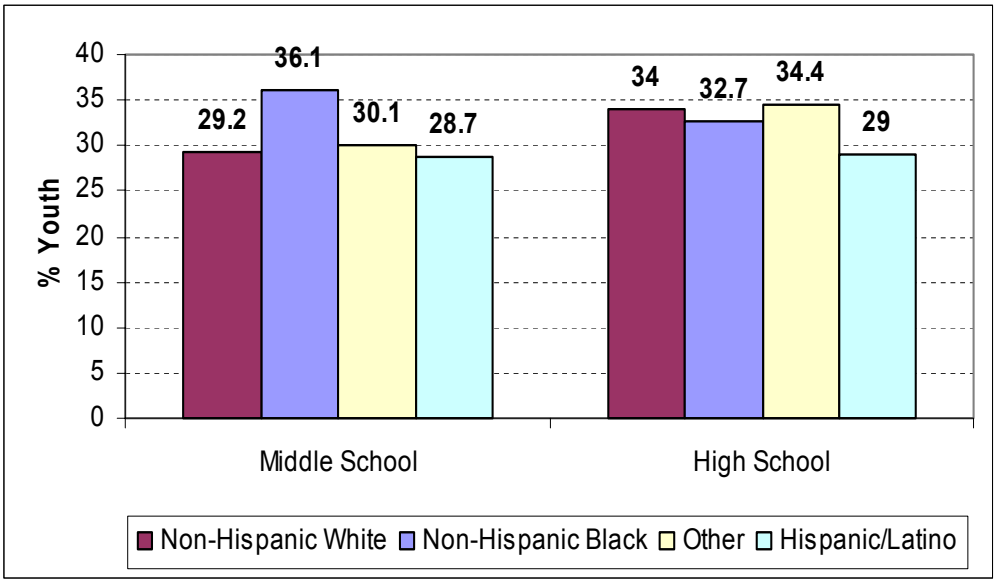


Note: Percentages represent retailer violations reported in the previous fiscal year (i.e. FY2000 rates are the result of inspections conducted in FY1999).

RI MHRH, 2005

Secondhand Smoke

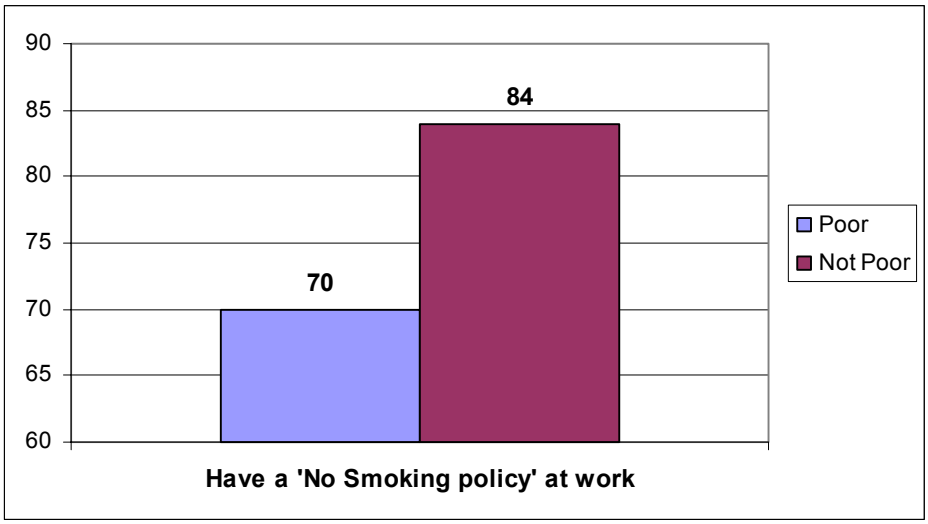
Youth who Live with Person who Regularly Smokes Cigarettes in the House/Apt.



Middle School YTS, 2003

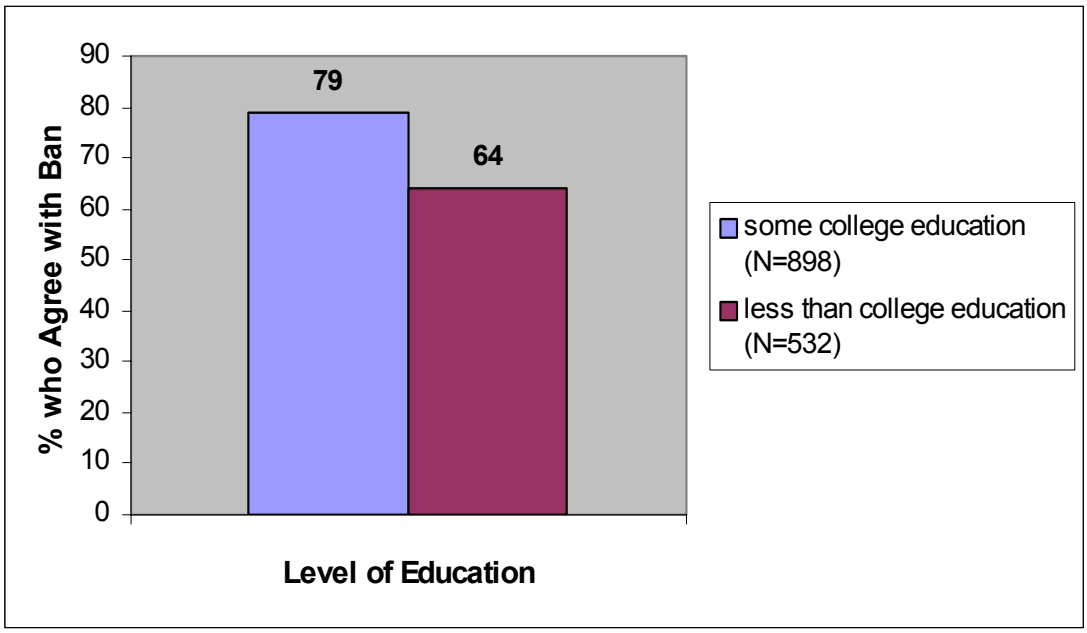
High School YTS, 2004

Employed Respondents with 'No Smoking' Policy at Work, Classified by Poverty Status



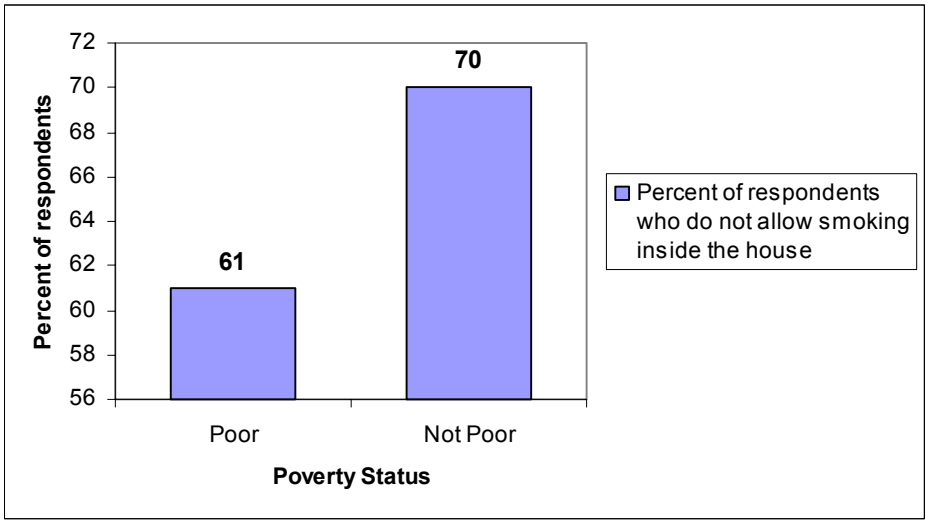
RI BRFSS, 2002

Education and Views on Worksite Smoking Ban



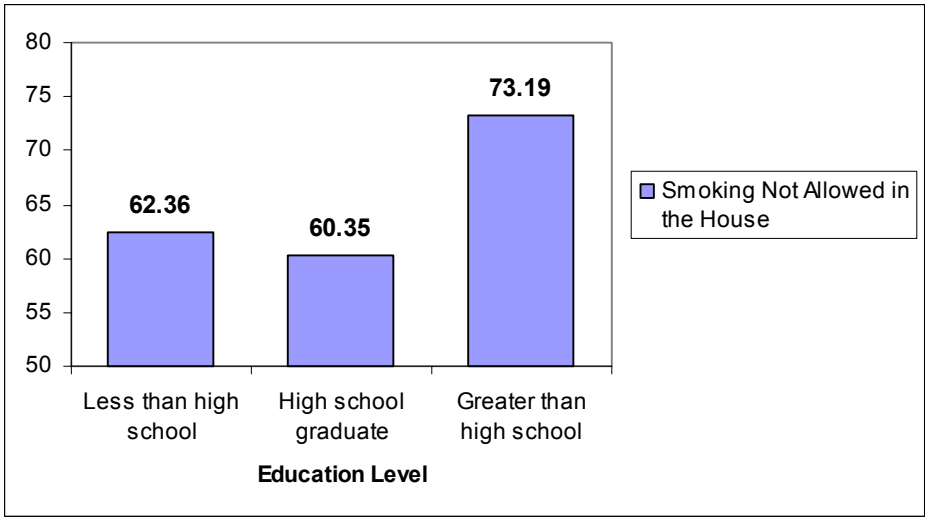
ATS, 2003

Respondents who do not Allow Smoking in the House, Classified by Poverty Status



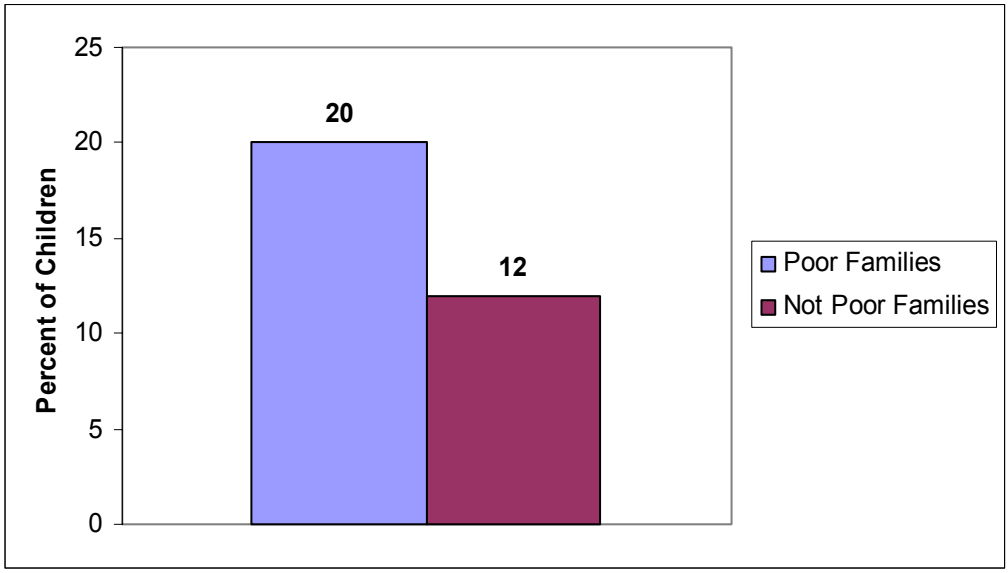
RI BRFSS, 2002

RI Smoke-free Homes, Classified by Smokers' Education Levels



RI BRFSS, 2002

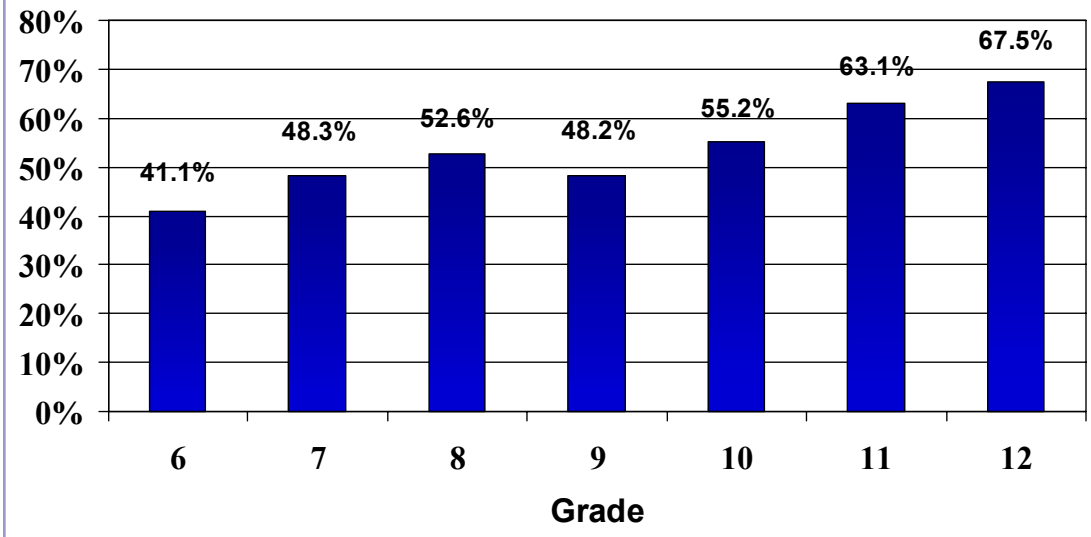
RI Children Exposed to Secondhand Smoke in the Car, Classified by Poverty Status



HIS, 2001

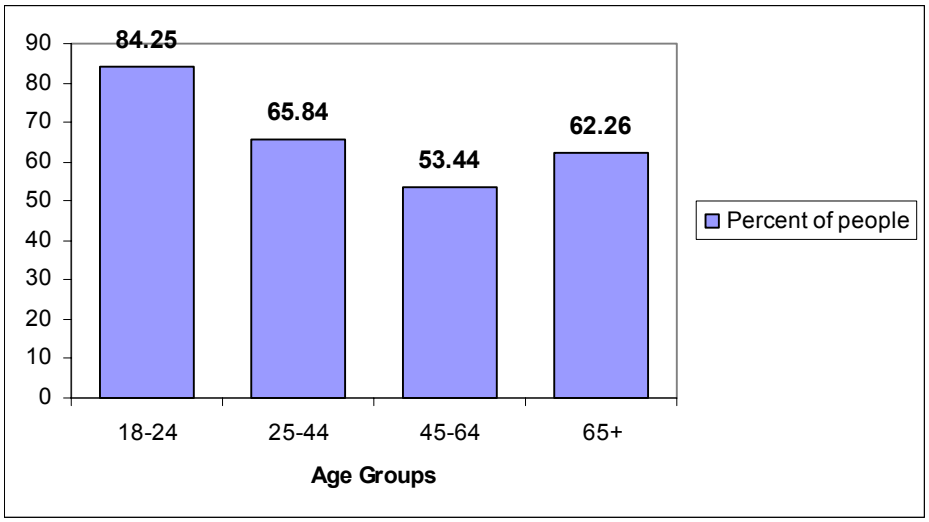
Cessation

% Current Youth Smokers Who Have Tried to Quit Smoking in the Past Year



ource?

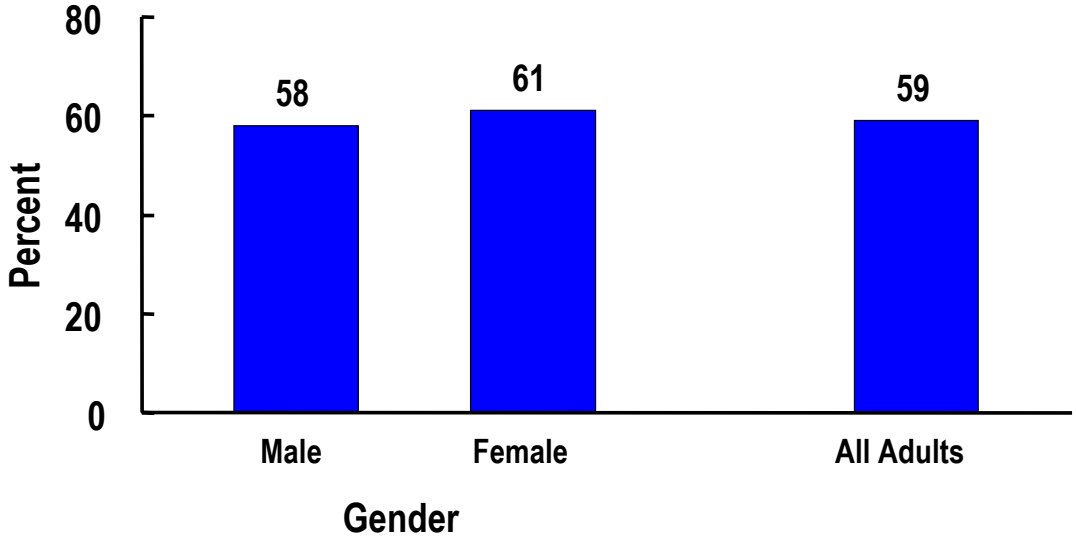
% RI Smokers Who Attempted to Quit Classified by Age Groups



* Tried to quit smoking for 1 or more days in the past year

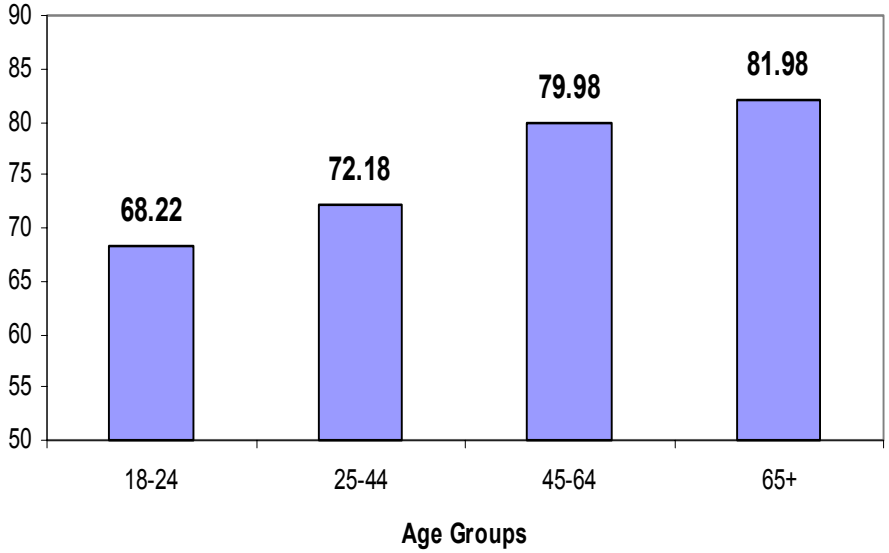
RI BRFSS, 2002

% RI Adults Who Smoke Who Tried to Quit During the Past Year, 2004



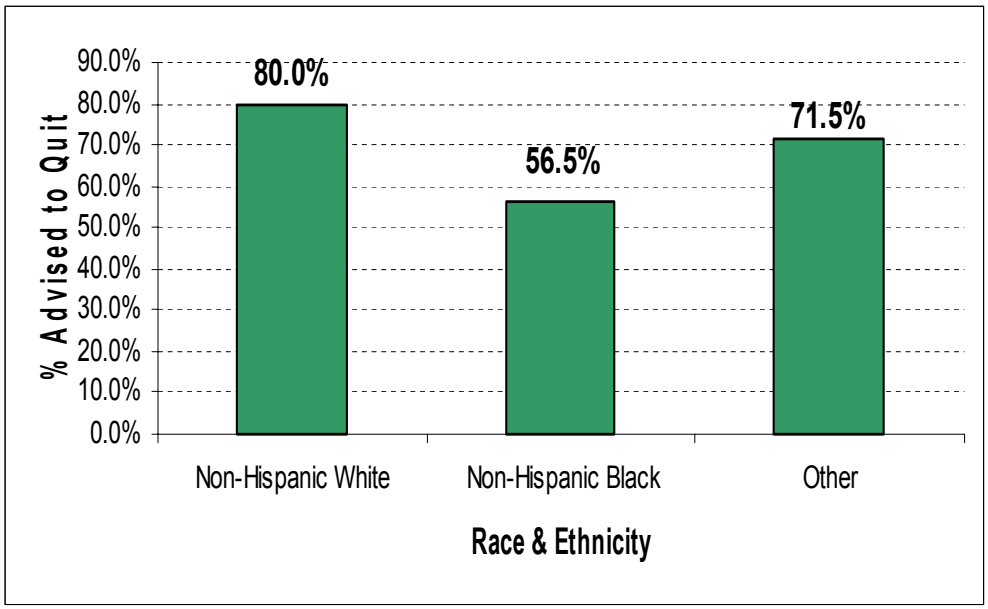
RI BRFSS, 2004

% Smokers Advised to Quit by Health Professionals, by Age



RI BRFSS, 2002

% Smokers Advised to Quit by Health Professionals, by R/E



RI BRFSS, 2004

Profile of Treatment Participants

- Insurance Coverage
  - Have some type of insurance = 81%
  - Do not have insurance = 16%
  - Missing = 3%
- Race/Ethnicity
  - White non-hispanic = 82.07% (N=572)
  - Hispanic = 7.17% (N=50)
  - Black non-hispanic = 6.60% (N=46)
  - Asian = 0.14% (N=1)
  - Native American = 1.72% (N=12)

Profile of Treatment Participants

- Income
  - $0 – 10,000 = 25.86% (N=181)
  - $10,001- 20,000 = 15.86% (N=111)
  - $20,001-30,000 = 20.86% (N=146)
  - $30,001 – 40,000 = 10% (N=70)
  - $40,001- 50,000 = 7% (N=49)
  - $50,000 + = 8% (N=56)

- Education
  - < 8th grade = 4.86% (N=34)
  - some high school = 12.14% (N=85)
  - high school/GED = 37.57% (N=263)
  - some college = 29.57% (N=207)
  - college grad = 11.43% (N=80)
  - post college = 3.43% (N=24)

Appendix B

Population Assessment Results

Population/Community Mentally Ill

(scale: 1-5)

Number of Informants 3 **Rating of Informant Consensus** 5

Tobacco Customs and Attitude of this Community/Group

Tobacco is an important part of socialization

Used for stress and symptom self-medication

Some are aware that tobacco is harmful, while others do not pay attention; there is tacit approval by many

Tobacco is not a priority for many

Many Providers have the attitude "*why take it away from them, they don't have much else?*"

Existing Programs/What is Now Being Done to Address Tobacco

Treatment Providers refer interested clients to cessation programs

Some Treatment Providers educate on the harmful effects of tobacco

Brown University is studying the effects of psychiatric medications on tobacco decision-making and behaviors

Communication Channels

Health Care Providers, Treatment Providers and organized Programs – e.g., Day Programs, Clubhouses, Community Mental Health Centers (CMHCs) – are central

Much of their social interaction occurs at organized Programs

Other channels: TV, family

Strengths for Addressing Tobacco

Active role of Treatment Providers and Programs with this group

Challenges to Addressing Tobacco

Tobacco plays a central role in socialization for this group that tends toward isolation

Symptoms interfere with internalizing tobacco education messages

Tendency to isolate makes communication difficult

Tobacco is part of the reward system and many providers do not believe it is a problem to address

Psychiatric medications cause weight gain; smoking is viewed as an appetite suppressant that can counter this

Lack of transportation to treatment

Programs

[None mentioned, except for Brown U. study]

Community Capacity

[Little involvement in issue]

Good Ways to Reach Community

Through Treatment Providers and Programs (3 of 3 informants)

National Alliance for the Mentally Ill (NAMI: 1 of 3 informants)

Mental Health Consumer Association (1 of 3 informants)

Other Potential Channels

Organizations addressing discrimination and minority health

Other Comments/Issues

Education and outreach to providers needed

Need simple materials requiring low literacy level

Population Assessment Results

Population/Community Unemployed

(scale: 1-5)

Number of Informants 2 **Rating of Informant Consensus** 4

Tobacco Customs and Attitude of this Community/Group

Tobacco use widely accepted and approved as a social/lifestyle activity; use encouraged

Aware of health risks, but still approve use; sense of invulnerability

Females smoke more than males (1 of 2 informants) or they smoke equally (1 of 2)

Existing Programs/What is Now Being Done to Address Tobacco

Mainly general state-wide efforts

Job Corp provides cessation services, but these are not very successful; they also post information on effects of smoking

Communication Channels

Native language-speaking peer groups

Workplaces

Training programs and Adult Education Centers

Community-based Organizations

Strengths for Addressing Tobacco

Rhode Island College (RIC) has an outreach program with monthly health workshops

Staff working with this group are supportive

[No other strengths identified]

Challenges to Addressing Tobacco

Generally not perceived as a 0roblem

Lack of English skills

Stress, low morale, and/or depression

Group “does not want to hear it.” Just interested in employment training

Community Capacity

Good Ways to Reach Community

Work with Adult Education providers (go through Dept. of Labor & Training and Dept. of Human Services)

Possibly: Agencies that disburse unemployment benefits

Other Potential Channels

Organizations dealing with: women’s health; domestic violence; health care access; discrimination; minority health

Other Comments/Issues

One informant recommends incentive programs to encourage people to quit

This group is often unaware of existing cessation services; these services need to be promoted in ways targeted to this population

Population Assessment Results

Population/Community Pregnant women

Number of Informants 4 [3 informant3 responded largely in terms of subgroups of pregnant women: Native American (NA), Latino (L), and pregnant/parenting teens age 12-20. Other informant was for Neighborhood health Plan (NHP) and reported on pregnant women covered by NHP . Comments specific to a certain subgroup will be indicated.]

Rating of Informant Consensus (scale: 1-5) 2 [Probably due to different communities represented]

Tobacco Customs and Attitude of this Community/Group

15% of pregnant women in NHP's Bright Start Program report smoking.

Teens have a passive attitude towards tobacco. They have knowledge of the harmful effects but are largely unwilling to change their behavior

According to our informant, RI Native American women do not smoke during pregnancy, but quickly return to smoking after birth.

The Latino informant reported that tobacco education is included in breastfeeding education. Latino smoking women tend to quit during pregnancy, but are more likely to return to smoking post-partum, unless they breastfeed.

Existing Programs/What is Now Being Done to Address Tobacco

Miriam Hospital

Brown University has a study

Quit Now Program

Communication Channels

Teens are especially communicate at school, after-school programs, malls, and pay attention to TV and the radio.

Strengths for Addressing Tobacco

There already exists a lot of information on smoking and its effects.

Challenges to Addressing Tobacco

Access and transportation to smoking cessation services

Smoking pregnant women often live in smoking homes and have approve of smoking

Not enough anti-smoking messages for pregnant women; Latino women largely obtain information from primary care physicians and the message often gets lost among all the other information the women are receiving.

Community Capacity

Good Ways to Reach Community/Group

Should have services in clinics and include tobacco education in prenatal childbirth and childbirth classes

Teens: education, media/marketing strategies, appeals through the health of their children

Native Americans: Brochures, flyers, educational materials

Other Potential Channels

Other Comments/Issues

Latino Informant: Current antismoking materials don't reflect cultural and ethnic backgrounds

Native American women largely share the larger Native American community's skeptical, even hostile attitude towards many tobacco control efforts [see Native American summary.]

Population Assessment Results

Population/Community Uninsured

(scale: 1-5)

Number of Informants 2 **Rating of Informant Consensus** 1

[Note: 1 of 2 informants felt that this group did not differ from the larger public in most aspects enquired about.]

Tobacco Customs and Attitude of this Community/Group

I1 [Informant 1]) No different from uninsured

I2) A larger problem in this population. Dissonance: Higher smoking rate than insured, but also fairly high disapproval.

I2) Talk of high cost of health problems associated with smoking

Existing Programs/What is Now Being Done to Address Tobacco

Cessation program at Health Center and American Lung Association & DOH programs

NHP offers NRT

Communication Channels

Health Centers are important

Accesses health care through employer-based organizations [SS: I don't know what these are]

Media influential

Strengths for Addressing Tobacco

Active Community-based Organizations (CBOs)

Health Centers

Challenges to Addressing Tobacco

Because of lack of insurance, don't have regular access to health care and don't have regular Primary Care Provider

Lack of health literacy a barrier

Poor communication and lack of sense of community

Community Capacity

Good Ways to Reach Community/Group

Through Community Health Centers

Through workplaces that do not provide insurance, especially retail and hospitality industries

CBOs

Other Potential Channels

Minority health, as 50% of Latinos are uninsured

Other Comments/Issues

Population Assessment Results

Population/Community Those with less education

(scale: 1-5)

Number of Informants 2 **Rating of Informant Consensus** 3.5

Tobacco Customs and Attitude of this Community/Group

Recognize hazards of tobacco, but do not necessarily see it as a big problem or want to quit

Many come from smoking households and approve of tobacco

Young smokers from recently emigrant families hide use from elders, while young smokers born here have a more 'in your face" rebellious attitde

Existing Programs/What is Now Being Done to Address Tobacco

DOHY Comprehensive Tobacco Control (CTC) programs

Southside Coalition in greater Providence

Earlier there was WORD (American Legacy-DOH-funded youth development initiative) conducted tobacco control work

The Smoke-Free Workplace law is working

One informant states: "A lot could be done with increased resources."

Communication Channels

Media, especially TV, most important

Workplaces. For new immigrants, workplaces are especially important as they want to learn what's expected of them there.

Churches are important for some

Community-based Organizations (CBOs) are important

Strengths for Addressing Tobacco

Many, especially among immigrants, are very law-abiding – even smokers acknowledge and abided by Smoke-Free Workplace law

Many don't want their children to smoke

Job-related training networks

CBOs

Challenges to Addressing Tobacco

Low literacy levels

:Lack of trust of government for some

Geographic mobility – many in this group move often

Need to identify and address their needs through dialog

Community Capacity

Leaders are more involved than the general community. For example, even in regards to the Smoke-Free Workplace law, many owners of hospitality establishments were supportive

Active enforcement of laws creates community social pressure to obey

Good Ways to Reach Community/Group

Housing projects may be a way to reach some

Workplaces

Social services, including: health-related vehicles (women and infants traveling van, etc.); job training and adult education programs

Media

Peer networks

Other Potential Channels

Minority health

Discrimination

Other Comments/Issues

Current educational materials not that effective with this population. Overly repetitive and not interesting enough. Need clear, concise, engaging messages

Population Assessment Results

Population/Community 18-24 yo

(scale: 1-5)

Number of Informants 2 **Rating of Informant Consensus** 3.5

Note: 1 informant reported largely on the college population (Col), the other on the non-college group (NCol)

Tobacco Customs and Attitude of this Community/Group

Both: Smoking no longer seen as cool

Both: People often claim to smoke "only once in a while" and do not identify as a smoker or that they are going to quit soon.

Both: See themselves as invulnerable

NCol: All know that smoking is not good

Col: Smoking is just a temporary behavior, they believe, and they will quit as soon as they leave college. Deny addictive potential
Survey of freshman/transfer students: 85% don't smoke at that time, though many take up smoking in subsequent years, almost doubling the 15% rate

Existing Programs/What is Now Being Done to Address Tobacco

NCol: Not much since WORD American Legacy-DOH-funded youth development initiative)

Col: Grants at URI through Cancer Prevention Research Center. Health Services at URI has added smoking to their yearly physician checklist, completed yearly on each patient.

NCol: No cessation services for this group. Services, to be acceptable, have to be easily accessed as youth feel "busy", whether they have scheduled activities or not

Communication Channels

Both: Cell phones, text messaging, Instant Messaging (IM), iPods, etc.

Both: Social life is #1

Both: Role models very important. Messages need to be based on an understanding of these models and the values they embody

NCol: Hip language/symbols, sometimes with gang origins

NCol: Workplaces very important, as sources of messages from employers and as the basis for social life. Also, having to go outside to smoke makes it much more difficult

Col: Smoke-free workplaces important in making smoking more difficult. As students leave college and transition into the workplace, this creates pressure to quit smoking. Employers are asking about smoking status in job interviews, and view smokers as having higher health costs and lower productivity – students are aware of this trend

Strengths for Addressing Tobacco

Both: The passion and enthusiasm of youth are a real asset. If they get behind a cause, they will really take it on

NCol: When efforts "political" (e.g., WORD), they have a wider appeal to this population:

> "The idea of youth connected to a movement that is not afraid to be politicized has huge potential. Tobacco as a symbol is a great opportunity. Awareness, youth perception, employment leads to hope and the ability to make healthy choices. When feeling hopeless, cigarettes provide a support, a crutch. When feeling hopeful, cigarettes feel awful."

Challenges to Addressing Tobacco

NCol: Distrust, and the essential role of authenticity if messages are going to be accepted. Information must be fact-based, not scare-based

NCol: Smoking an important communal act for this group that feels it has little. Cigarette tax, by raising price, may inadvertently increase the importance of communal sharing of cigarettes, viewed as a scarce resource

Col: Sense of invulnerability; peer pressure to engage in a variety of risky behaviors (smoking, drinking, gambling)

Col: Feel "they've heard about it; they know about it; don't bother them"

Community Capacity

Good Ways to Reach Community/Group

Both: Use of cell phones and text messaging may work

Col: Web-based cessation services may work for this group; NCol group less web-savvy

Both: Messages must be engaging, not preachy, pay close attention to youth language and culture

NCol: Messages/efforts must address the real needs of this population and relate to the wider issues that they face

Other Potential Channels

Col: If there were active efforts to deal with alcohol, other drugs, pr gambling, which there are not at present, these efforts could also be used to address tobacco

Other Comments/Issues

NCol: As smoking is no longer cool, antismoking messages no longer need to counter this. Somehow, strategies need to be based on a deeper understanding of the nature of addiction

NCol: Aware of British program, using slick collectable cards (with graphic images on front and tobacco facts on back). Efforts to reach out to this population need to be similarly creative in terms of being polished and desirable.

Population Assessment Results

Population/Community Lesbian, Gay, Bisexual & Transgendered (LGBT)

Number of Informants 3 **Rating of Informant Consensus** m (scale: 1-5)

Note: 1 of 3 informants spoke explicitly about LGBT youth

Tobacco Customs and Attitude of this Community/Group

There were differing opinions among informants as to the extent to which tobacco is perceived as a problem in this community. Two felt that many in the LGBT community were indifferent, while one felt that pressure from the larger society that smoking is bad is starting to impact LGBT attitudes toward tobacco

Smoking is a central aspect of socialization. Conversations are often initiated around bumming a cigarette. A number of LGBT functions schedule in smoking breaks; this is often accepted.

Older gay men sometimes have AIDS survivor guilt: If AIDS didn't get me, nothing else will

Many lesbians believe they are destined to get cancer [This may become both a barrier to tobacco control and an opportunity, if the links between these two are made]

Existing Programs/What is Now Being Done to Address Tobacco

The Try to Stop line is in *Options* (gay paper)

In general, ads are not specific for LGBT population, so have reduced impact. However, recent RI TCP ads in *Options* were good

Fenway Community Health Center (Boston health center with specialized services for LGBT community) is funding (do they mean "conducting") a tobacco study

There is a lesbian cancer project in RI that secondarily addresses tobacco

Communication Channels

LGBT community communicates through coded symbols

It is electronically savvy and uses web sites, and listservs (electronic forums via email)

Social life is a large feature of this community: clubs (huge scene), bars and house parties

There are a few media outlets: *Options*, *Bay Windows*, *Phoenix*, Equity Options, Edge Providence (web site: http://www.edgeprovidence.com/). Most media outlets are geared toward socialization. As a result, public health messages can get lost

The LGBT community tends to congregate around the greater Providence area, though small house parties and potlucks are held elsewhere

Strengths for Addressing Tobacco

The community is coming together around issues like HIV/AIDS

Channels are open with LGBT-friendly business owners

One respondent said "visuals are effective with gay youth. Show what is in tobacco and project what the effects can be for them"

[See also some of the responses in Communication Channels section]

Challenges to Addressing Tobacco

Competing issues. Tobacco is low on priorities

Among youth, talking about tobacco is often viewed as a fruitless and tiring exercise

There are subgroups and cliques within the LGBT community

There are no RI services reaching LGBT of color; they are not on anyone's radar and would not fit into "mainstream" LGBT marketing and messaging

Community Capacity

Good Ways to Reach Community/Group

Gay media [See Communication Channels]

Bars and coffee houses

LGBT professional networks and organizations

Philanthropic Foundations: Gill Foundation, Legacy Foundation

Welcoming churches, esp. Unitarian and Congegationalist

Other Potential Channels

HIV/AIDS empowerment initiatives

Groups dealing with homophobia and diversity training

According to 1 informant, these initiatives are not connecting with gay youth

Other Comments/Issues

Many tobacco control materials are not culturally sensitive for this population, e.g., "My husband and I quit smoking together" rather than "My partner and I quit smoking together"

Poor LGBT persons are often ignored as stereotype is that this community is financially well-off

This community often feels ignored. One informant said: "It is powerful when mainstream CBOs initiate activities for the LGBT population without being prompted"

Two political leaders were singled out as key influential leaders of the LGBT community: Mayor David Cicilline, and House Majority Leader Gordon Fox

Appendix C

Rhode Island Disparities Strategic Plan

GOAL 1. Identify the interrelationships between social, environmental, and individual factors contributing to tobacco use in order to develop and implement targeted programs

Strategy 1.1 *Create a new or integrate with an existing coalition bringing together those concerned with multiple health problems in order to address health disparities as a social justice issue.*

Objective 1.1.1. Identify other coalitions working with disparately affected populations and consider joining their initiative. If no existing coalition is identified: Identify and recruit other organizations and issues that can join with tobacco control advocates, i.e. obesity, chronic disease, or diabetes.

Action a: Identify existing DOH or community-based coalitions.

Action b: If no suitable existing coalition is identified, develop a recruitment plan for a new coalition.

Action c: Create a list of targeted organizations and agencies.

Action d: Recruit and convene key stakeholders and decision-makers from the targeted organizations and agencies.

Strategy 1.2 Collect *information (qualitative and/or quantitative) on social and individual factors affecting tobacco use in disparately affected populations to increase effectiveness in programming and interventions.*

Objective 1.2.1. Conduct a needs assessment to identify social and individual factors affecting tobacco use among disparately affected populations.

Action a: Identify people to be assessed and how the assessment can be conducted (e.g. who will conduct it and how to fund it).

Action b: Conduct the assessment.

Action c: Identify social and cultural forces that drive people to smoking.

Action d: Share the information obtained from the needs assessment with agencies serving disparately

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affected populations to help them integrate with and improve the services they deliver.

Strategy 1.3 *Develop and conduct a marketing campaign on social justice.*

Action a: Identify funding resources; ask for time and/or money from coalition members.

Action b: Refine and redefine the concept of "social justice."

Action c: Educate populations that have not been reached (e.g. the poor).

GOAL 2. Identify and coordinate stakeholders to develop and enhance tobacco prevention and control initiatives within their disparately affected populations

Strategy: 2.1 *Identify organizations to help recruit key informants, stakeholders and potential partners from each of the disparately affected populations.*

Objective 2.1.1. Identify common ground/interests between disparately affected populations/communities and advocates for tobacco control and improved health and healthcare services.

Action a: Use the staff discussed in Strategy 6.3 for staffing support.

Action b: Talk to someone at Crossroads of RI to gather information about other collaborating agencies/resources (e.g. using their Blue Book)

Action c: Get recommendations from the Department of Health and other state agencies (e.g. DOH, DHHS, DEA, MHRH, DCYF, DOE, etc.) to identify key informants

Action d: Contact local government offices for recruitment of key informants

Action e: Contact the organizations listed in the chart developed by this group entitled "Organizations that could partner or connect us with disparately affected populations in tobacco use"

Action f: Involve insurance companies (e.g. United Healthcare, Neighborhood Health Plan, Blue Cross/Blue Shield of RI).

Strategy: 2.2 *Educate stakeholders on tobacco issues related to their populations.*

Objective 2.2.1. Provide insight to state system representatives on needs of disparately affected populations.

Action a: Utilize information gathered by the needs assessment discussed in Strategy 1.2 to prepare presentations, talking points, etc. for new recruits.

Action b: Develop large and individual forums (e.g. conferences) for dissemination of the information gathered by the needs assessment discussed in Strategy 1.2. The DOH Health Disparities Team should be involved in these efforts.

Strategy 2.3 *Identify and educate legislative advocates for each population and bring them together with other "champions."*

Objective 2.3.1. Obtain Governor's involvement in issues involving disparately affected populations and tobacco use.

Action a: Determine venue and strategy to involve the Governor.

Action b: Convene a meeting (or other venue) to enlist the Governor's involvement including his briefing advisors.

Objective 2.3.2. Create a ground swell and mobilize community support to address tobacco-related heath disparities.

Action a: To identify and recruit champions, contact Ocean State Action, The Poverty Institute, The George Wiley Center, Healthcare for All, Providence Plans, etc.

Action b: Establish the commitment of champions who will develop and participate in a campaign.

Action c: Develop and implement an educational campaign for the public

Action d: Develop and implement an organizing campaign

Action e: Convey the message that the tobacco industry is targeting the vulnerable.

Action f: Collect and utilize personal success stories

GOAL 3. Create and enforce tobacco control policies

Note: In the actions described to achieve this goal we assume that, in many circumstances, community mobilization is necessary in order to bring about desired policy changes.

Action Framework: There are a number of **common action steps** for successful community mobilization leading to policy change. ***These steps are assumed in all the Objectives involving community mobilization under Goal 3.*** [In some cases other specific actions are also identified.] Among these common steps are:

Common Action Step a: Examine existing state and local laws and legal decisions in order to determine what types of regulation are currently allowed.

Common Action Step b: Identify elected officials and/or their staff members to champion the desired tobacco control policy changes.

Common Action Step c: Educate and mobilize communities.

Common Action Step d: Conduct media advocacy.

Strategy 3.1 *Increase restrictions and enforcement of restrictions on the sales and number of retailers of tobacco in municipalities representing disparately affected populations.*

Objective 3.1.1. Increase the proportion of municipalities with policies that ban tobacco vending machine sales in places accessible to young people in communities where disparately affected populations live.

Action a: Survey vending machines in geographic areas where disparately affected populations live in order to determine extent of compliance with existing vending machine regulations.

Continue with Common Action Steps.

Objective 3.1.2. Increase the proportion of municipalities with policies that require retail licenses to sell tobacco products in communities where disparately affected populations live.

Action a: Seek enabling state legislation allowing municipalities to require municipal licenses for tobacco sales in addition to state licensing requirements.

Action: b Research similar laws in other states.

Objective 3.1.3. Increase the proportion of municipalities with policies that control the location, number, and

density of retail outlets that sell tobacco in communities where disparately affected populations live.

Objective 3.1.4. Increase proportion of municipalities with policies that control self-service tobacco sales in communities where disparately affected populations live.

Objective 3.1.5. Increase number of compliance checks conducted by enforcement agencies in communities where disparately affected populations live.

Strategy 3.2 *Assure availability of evidence-based tobacco use cessation services to tobacco users in Rhode Island.*

Objective 3.2.1. Fund tobacco cessation services for uninsured Rhode Islanders.

Action a: Develop a mechanism to provide cessation services to the uninsured.

Strategy 3.3 *Reduce tobacco industry influences.*

Objective 3.3.1. Reduce the extent and type of retail tobacco advertising to disparately affected populations.

Action a: Pursue generic local advertising and signage ordinances.

Objective 3.3.2. Pursue state legislation to regulate the extent and type of retail tobacco promotions in communities.

Action a: Pursue state legislation to regulate promotion.

Objective 3.3.3. Reduce the extent of tobacco industry sponsorship of public and private events among groups that represent disparately affected populations.

Action a: Increase the proportion of organizations with policies that regulate tobacco industry sponsorship of public events among groups representing disparately affected populations.

GOAL 4. Develop and implement comprehensive and innovative programming to eliminate tobacco use among disparately affected populations

Strategy 4.1 Assure *all programs are culturally and linguistically appropriate, for example, programs appropriate for those*

with low literacy.

Objective 4.1.1. Identify existing tobacco control programs and models that are successfully working with disparately affected populations.

Action a: DOH develops a list of tobacco control programs, strategies, best practices and models for the various disparately affected populations.

Action b: DOH provides the Governor and his advisory committee with key contacts and programs related to tobacco control in the state.

Objective 4.1.2. Deliver technical assistance and training to organizations working with disparately affected populations to help them utilize culturally and linguistically appropriate programs.

Action a: Develop a sub-committee made up of DOH staff and personnel from disparately affected populations to develop and review plans.

Action b: Establish a sub-committee and train the committee to seek and identify resources and possibly to deliver them.

Strategy 4.2 *Conduct workforce development sessions and work with existing certification process to educate personnel of agencies and organizations who work with identified disparately affected populations on eliminating tobacco use.*

Objective 4.2.1. Identify workers engaged with disparately affected populations and educate them on how to work on eliminating tobacco use.

Action a: Refer to the stakeholders list identified in Strategy 2.1.

Action b: Refer to Strategies 2.2 and 2.3 their associated action steps on educational resources.

Action c: Work with agencies, schools, and other organizations to distribute current resources such as awareness and education materials and marketing campaign materials.

Action d: Collaborate with programs that offer community classes (i.e. budgeting and parenting) to disparately affected populations in order to educate staff and participants on the costs and health hazards of tobacco use.

Action e: Develop processes of acknowledgment and/or incentives to participate.

Objective 4.2.2. Educate state-funded subcontractors on tobacco use among disparately affected populations and use regulatory processes and policies to require participation.

Action a: Work with licensure boards/regulation facilities to incorporate a component on tobacco use in disparately affected populations

Strategy 4.3 *Raise awareness and involvement on the issue of tobacco use among disparately affected populations.*

Objective 4.3.1. Raise visibility and support through media. In doing this, avoid stereotypes, focus on systemic issues and expose industry targeting.

Strategy 4.4 *Affect systems change regarding smoking and socializing among disparately affected populations.*

Objective 4.4.1. Develop and disseminate materials to educate regarding and discourage the use of tobacco as a means of socializing;

Objective 4.4.2. Strengthen enforcement of smoke-free workplace and public place law to discourage smoking as a social habit

Action a: Assess present level of compliance.

Action b: Address weaknesses in present compliance enforcement.

GOAL 5. Improve the effectiveness of the health care system as a channel to promote tobacco control and prevention

Strategy 5.1 Advocate *that insurance companies provide coverage for prevention and intervention for tobacco treatment and disparately affected populations.*

Objective 5.1.1. Support the development of a mechanism for health care providers to be able to be reimbursed for prevention and intervention services including use of reimbursement service codes.

Action a: Educate disparately affected populations regarding the legislative mandate to cover cessation

treatment.

Action b: Inform tobacco treatment providers and health care professionals regarding insurance reimbursement procedures for tobacco treatment.

Objective 5.1.2. In the absence of a legislative mandate, advocate for coverage for evidence-based treatment, including assessment, NRT and other interventions among the uninsured and Medicaid populations.

Strategy 5.2 *Support and expand accessible tobacco control service delivery to communities with disparately affected populations (e.g. new locations for mobile teams could include pharmacies and supermarkets)*

Action a: Identify populations to be targeted.

Action b: Develop strategies to provide mobile, nontraditional services to identified populations.

Action c: Create a strategy to obtain and secure funding for these services, including services to the uninsured.

Action d: Assure adequate access to services in all insurance plans.

Action e: Develop a resource list of cessation counselors

Action f: Disseminate the list of cessation counselors to insurance companies, health centers, providers, etc.

Strategy 5.3 *Increase involvement of medical professionals and allied health care providers in providing tobacco control services to disparately affected populations.*

Action a: Identify advocates within healthcare provider communities (MD's, nurses, nurse practitioners, chiropractors, dentists, student assistance counselors, etc.) to motivate and educate their peers about tobacco-related health disparities.

Action b: Provide training to the total health care community (e.g. providers, staff, insurance companies, community organizations, schools) using materials (culturally and linguistically appropriate) on how to intervene with smokers, especially those in disparately affected populations. In conducting this training, it is important to explore disincentives to diagnosis and treatment.

Strategy: 5.4 *Advocate that curriculum at medical and allied health professional schools require a class on health disparities,*

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including tobacco use prevention and control Classes should include information on the causes of health disparities as well as how to eliminate disparities

Action a: Advocate for a requirement that health professionals must take a class on health disparities in order to obtain or renew a license to practice in Rhode Island.

Action b: Obtain CME's and CEU's for conferences and trainings on health disparities for all health care professionals practicing in Rhode Island.

GOAL 6. Identify funding and address resource constraints

Strategy *6.1* *Identify needs and cost of implementing this disparities strategic plan.*

Action a: Build a justification/cost base and inform potential funders.

Strategy 6.2 Create *an advocacy structure together with the new coalition and the Department of Health to increase funding for tobacco prevention and control with disparately affected populations.*

Action a: Create a comprehensive list of public and private grant opportunities.

Action b: Develop an inventory of outreach methods utilized by agencies that focus on or serve disparately affected populations to prevent duplication and lost opportunities.

Action c: Establish link so that a portion of the excise tax goes to fund tobacco-related disparities programming.

Action d: Consider working with coalition and/or partnerships

Action e: Seek philanthropic grants

Action f: Investigate how to fund community organizations that do not have 501.c3 nonprofit designations.

Strategy 6. 3 *Allocate staffing support to help implement the plan.*

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GOAL 7. Identify and clarify data needs, as well as appropriate sources and methods to obtain them

Strategy: 7.1 *Evaluate current methods of data collection (qualitative and quantitative) in terms of their ability to obtain needed information on disparately affected populations. Use evaluation criteria such as: Do they ask the right questions? Are they culturally and linguistically sensitive? Are they geographically representative? Do they utilize trusted stakeholders to poll specific populations?*

Strategy: 7.2 *Increase the quality and quantity of data collected on disparately affected populations.*

Action a: Identify who is collecting and using data on disparately affected populations.

Action b: Collect the data on an annual basis.

Action c: Identify the gaps in and barriers to data collection

Action d: Encourage the inclusion of sexual orientation in state prevalence and risk factor surveys.

Action e: Encourage researchers to include tobacco related questions for disparately affected populations.

Action f: Require Comprehensive Tobacco Control Programs [CTCs] to gather data through community events and programs.

Appendix D

Eliminating Tobacco-Related Health Disparities in Rhode Island

Implementation Plan for March 2007 – February 2008

Strategy 1.1 *Create a new or integrate with an existing coalition bringing together those concerned with multiple health problems in order to address health disparities as a social justice issue.* [**Associated Goal 1:** Identify the interrelationships between social, environmental, and individual factors contributing to tobacco use in order to develop and implement targeted programs]

Objective 1.1.1. Identify other coalitions working with disparately affected populations and consider joining their initiative. If no existing coalition is identified: Identify and recruit other organizations and issues that can join with tobacco control advocates, i.e. obesity, chronic disease, or diabetes.

ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1*	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: Identify existing DOH or community-based coalitions.	**ALL**	**DOH – inside HEALTH DPG – outside HEALTH**	**X**				
Action b: If no suitable existing coalition is identified, develop a recruitment plan for a new coalition.	**ALL**	**Disparities Planning Group (DPG)**		**X**			
Action c: Create a list of targeted organizations and agencies.	**ALL**	**Disparities Planning Group**	**X**				
Action d: Recruit and convene key stakeholders and decision-makers from the targeted organizations and agencies.	**ALL**	**Disparities Planning Group**			**X**		

*Q1 = April - June 2007

Q2 = July – September 2007

Q3 = October – December 2007

Q4 = January –March 2008

Strategy: 2.1 *Identify organizations to help recruit key informants, stakeholders and potential partners from each of the disparately affected populations.* [**Associated Goal 2:** Identify and coordinate stakeholders to develop and enhance tobacco prevention and control initiatives within their disparately affected populations]

Objective 2.1.1. Identify common ground/interests between disparately affected populations/communities and advocates for tobacco control and improved health and healthcare services.

ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: Use the staff discussed in Strategy 6.3* for staffing support.	**ALL**	**DOH**	**X**				
Action b: Talk to someone at Crossroads of RI to gather information about other collaborating agencies/resources (e.g. using their **White** Book)	**ALL**	**Kelly & Pat**	☑				
Action c: Get recommendations from the Department of Health and other state agencies (e.g. DOH, DHHS, DEA, MHRH, DCYF, DOE, etc.) to identify key leaders.	**ALL**	**DOH – prepare initial list for DPG to review and add to.**	**X**				
Action d: Contact local government offices for recruitment of key informants	**ALL**	**DOH with help from Laura Hosley**	**X**		**X**		
Action e: Contact the organizations listed in the chart developed by this group entitled "Organizations that could partner or connect us with disparately affected populations in tobacco use"	**ALL**	**DOH**		**X**			
Action f: Involve insurance companies (e.g. United Healthcare, Neighborhood Health Plan, and Blue Cross/Blue Shield of RI.)	**ALL**	**DOH**		**X**			

* Strategy 6.3: *Allocate staffing support to help implement the plan.* (GOAL 6. Identify funding and address resource constraints)

Strategy 3.1 *Increase restrictions and enforcement of restrictions on the sales and number of retailers of tobacco in municipalities representing disparately affected populations.* [**Associated Goal:** Create and enforce tobacco control policies]

Objective 3.1.1. Increase the proportion of municipalities with policies that ban tobacco vending machine sales in places accessible to young people in communities where disparately affected populations live.

ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: Survey vending machines in geographic areas where disparately affected populations live in order to determine extent of compliance with existing vending machine regulations.	**ALL**	**Comprehensive Tobacco Control Coordinators (CTC)**	**X**	**X**			**1. Gather/produce data to enable legislation and educate legislators** **2. Document compliance issues**
Action b: Examine existing state and local laws and legal decisions in order to determine what types of regulation are currently allowed.	**ALL**	**CTC**	**X**	**X**			**Increase capacity and knowledge to measure compliance**
Action c: Identify elected officials and/or their staff members to champion the desired tobacco control policy changes.	**ALL**	**CTC & Liz Gemski, ACS**			**X**		**List of identified officials & champions**
Action d: Educate and mobilize communities.	**ALL**	**CTC**		**X**			**Increase community support for tobacco control policies**
Action e: Conduct media advocacy.	**ALL**	**CTC**		**X** Sept.	**X**	**X**	**Increase community support for tobacco control policies**
Action f: Ask Substance Abuse Community Task Forces to do the mapping and do the GIS training.	**ALL**	**CTC**	**X**				**1. Gather/produce data to enable legislation and educate legislators** **2. Document compliance issues**

Strategy 3.2 *Assure availability of evidence-based tobacco use cessation services to tobacco users in Rhode Island.* [**Associated Goal:** Create and enforce tobacco control policies]

Objective 3.2.1. Fund tobacco cessation services for uninsured Rhode Islanders.

ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: Develop a mechanism to provide cessation services to the uninsured		**DOH**	**X**	**X**	**X**	**X**	**Contract with organization to deliver services**
Action b: Media Outreach – to highlight services		**DOH**	**X**				**Regulations Advertising Campaign Focus group**
Action c: Increase Funding		**Coalition (Strategy 1.1) & CHRI**				**X**	
Action d: Recruit participants and refer to health centers (like backpack giveaways)		**CTC & DOH**	**X**				**Campaign to reach the hard to reach**
Action e: Adapt materials to be appropriate for audience		**DOH**	**X**				

Strategy 4.1 *Assure all programs are culturally and linguistically appropriate, for example, programs appropriate for those with low literacy.* [**Associated Goal:** Develop and implement comprehensive and innovative programming to eliminate tobacco use among disparately affected populations.]

Objective 4.1.1. Identify existing tobacco control programs and models that are successfully working with disparately affected populations.

ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: DOH develops a list of tobacco control programs, strategies, best practices and models for the various disparately affected populations.	**All**	**DOH**	**X**	**X**			
Action b: DOH provides the Governor and his advisory committee with key contacts and programs related to tobacco control in the state.	**All**	**DOH**			**X***		

*Requires data from CTC pilot project.

Objective 4.1.2. Deliver technical assistance and training to organizations working with disparately affected populations to help them utilize culturally and linguistically appropriate programs.

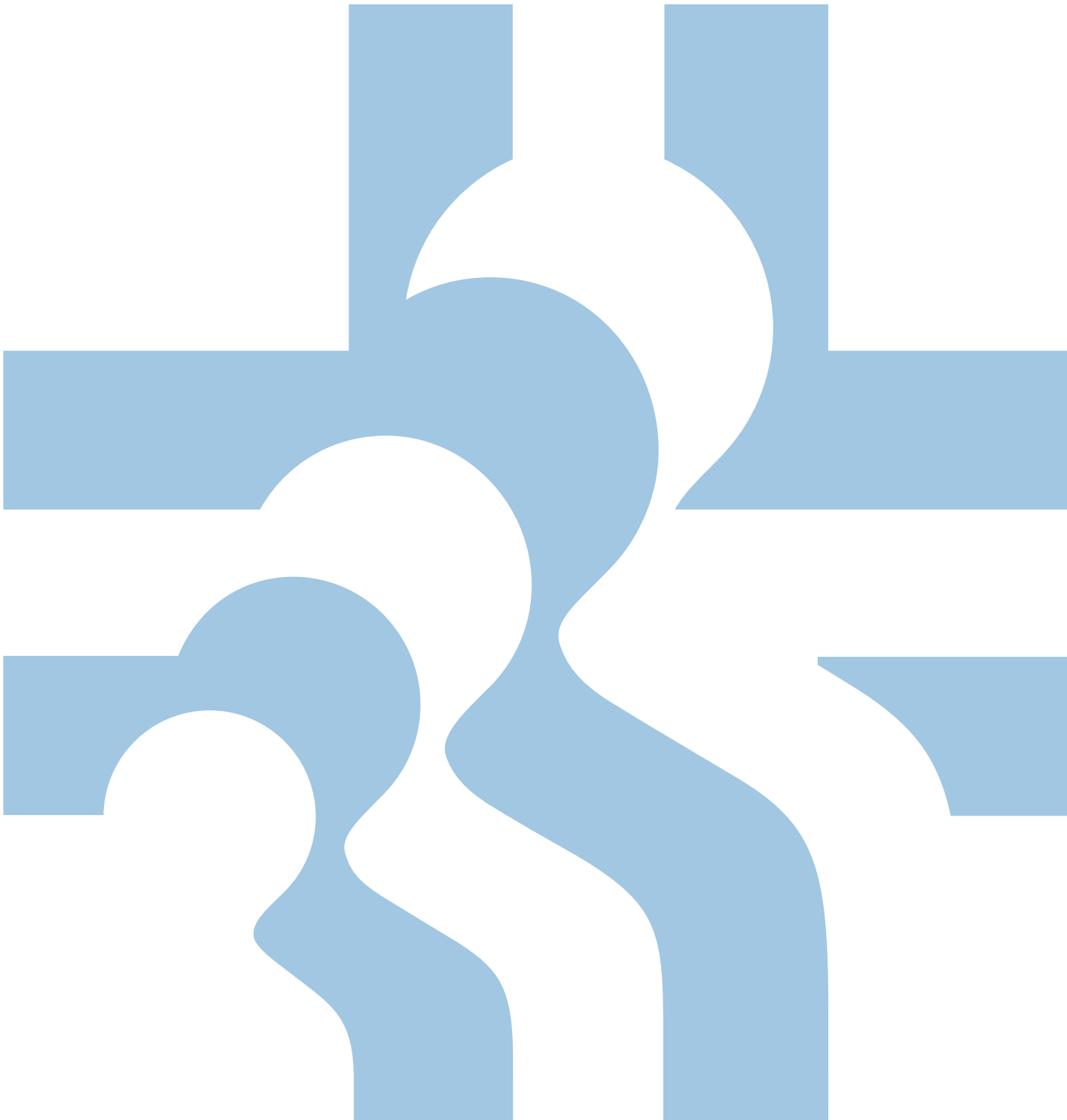
ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: Develop a sub-committee made up of DOH staff and personnel from disparately affected populations to develop and review plans.		**Carrie Bridges – Health Disparities Team**	*				
Action b: Establish a sub-committee and train the committee to seek and identify resources and possibly to deliver them.		**Carrie Bridges – Health Disparities Team**	*				

* Check with Carrie.

Strategy: 7.2 *Increase the quality and quantity of data collected on disparately affected populations.* [**Associated Goal:** Identify and clarify data needs, as well as appropriate sources and methods to obtain them.]

ACTIVITIES	TARGET GROUP	LEAD ROLES	Q1	Q2	Q3	Q4	ANTICIPATED OUTPUTS
Action a: Identify who is collecting and using data on disparately affected populations. *	**All**	**DOH & Carrie Bridges – Health Disparities Team**	**X**				**Check with Carrie.**
Action b: Collect the data on an annual basis. *	**All**	**DOH & Carrie Bridges – Health Disparities Team**	**				
Action c: Identify the gaps in and barriers to data collection.	**All**	**DPG**	**				
Action d: Encourage the inclusion of sexual orientation in state prevalence and risk factor surveys.	**All**	**Carolyn & Carrie**	**				
Action e: Encourage researchers to include tobacco related questions for disparately affected populations.	**All**	**Carrie's group & Data Sub-committee (?)**	**				
Action f: Require Comprehensive Tobacco Control Programs [CTCs] to gather data through community events and programs.	**All**	**DOH**	**X**	**X**	**X**	**X**	

* The Coalition for the Homeless maintains a database called the Homeless Management Information System (HMIS) of RI homeless clients. Kim Harris mentioned that mental health and substance abuse is actually doing a data merge. Check with Kim for details. Betty mentioned doing a qualitative and quantitative data collection/analysis.
** Check with Carrie.

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